STATE TITLE V BLOCK GRANT NARRATIVE
STATE: ME
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

All appropriate Assurances, Non-construction Programs, and Certifications regarding debarment and suspension, drug free work place requirements, lobbying, program fraud civil remedies act, and environmental tobacco smoke are on file in the Bureau of Health's, Division of Family Health and will be made available for review. Requests can be made through email to: Mary.Colson@maine.gov or by telephone at 207-287-9917.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

MCH programs elicit ongoing public input and consumer representation on committees and in activities. The CSHN and Youth Suicide Prevention Programs have successfully engaged youth in planning and advisory capacities resulting in youth oriented materials and activities specific to their needs. The CSHN Program actively involves parents on the advisory committee. Parents and consumers are recognized as critical components of successful programs and their input has been assured through their integration into routine program functions.

/2005/ The annual MCHBG planning and reporting processes, as well as, the upcoming FY05 application have been discussed with the Joint Advisory Committee (Genetics and CSHN Programs), Newborn Hearing Advisory, and Childhood Lead Poisoning Prevention Advisory Committees, with requests made for public input.

Planning for the 5-year comprehensive strengths and needs assessment began in the fall 2003 and is ongoing. Consumer, provider, and family input has been solicited at every opportunity at public forums such as committee and grantee meetings, conferences, and liaison groups. //2005//

Annually a notice is placed in local newspapers (Copy attached) indicating that the block grant application is being prepared and will be made available upon request to review and provide comment. ***/2006/ No requests were made for copies and no comments were received on the grant application. //2006//***

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Geography

The demographic and geographic factors that account for Maine's uniqueness among the New England states are the very same factors that create complex challenges for the Bureau of Health's Division of Community Health and Division of Family Health as they strive to improve health outcomes for the state's 1.3 million residents.

/2006/ All other five New England states can fit into the ~35,385 square miles occupied by the state of Maine. The population is distributed unevenly across the state; a third (35.8%) of Mainers live in the two southernmost counties (Cumberland and York), which together account for only 7% of the square miles in the state. Statewide we average only 41.3 people per square mile, as compared to 79.6 people per square mile in the United States as a whole. The population density varies dramatically across the state, from 317.9 people per square mile in Cumberland County, where Maine's largest city, Portland, is located, to 4.3 people per square mile in Piscataquis County. Statewide, 59.8% of the population lives in rural areas, as compared with 21.0% of the US population overall. In five Maine counties, 90% or more of the population lives in rural areas; two of these counties are 100% rural. Maine's large geographic area and widely dispersed population create challenges for accessing health care.

MCH populations (i.e., children, including those with special health needs and women of reproductive age) represent a significant proportion of Maine's population. In 2002, children under 18 years made up 21.4% of the state's 1.3 million people, with a range from 19.7% to 22.9% across the state's 16 counties [1] (Comprehensive Strengths and Needs Assessment - CSNA) Children represented a smaller proportion of the population in Maine than they did in the United States as a whole, where 25.7% of the population was under 18 years of age.[2] (CSNA)

In 2000, 32.4% of Maine households included one or more children under 18 years, as compared with 36.0% of US households. The range across Maine counties was 30.1% to 35.3%. [3] (CSNA) 6.2% of Maine households consisted of a female householder with her own children under 18 years of age and no husband present; the range across counties was 5.0% to 7.5%.[3] (CSNA) The comparable figure for the United States was 7.2%. [142] (CSNA)

Grandparents are the primary caregivers for a small proportion of children in Maine. The 2000 Census found that 1.7% of Maine adults aged 30 and over lived with grandchildren under 18 years of age. Similarly, 1.7% of Maine households included grandparents living with grandchildren. More than a third (38.9%) of the grandparents who lived with grandchildren were "grandparent caregivers," defined as having primary responsibility for coresident grandchildren younger than 18. A third (28.1%) of grandparent caregivers were aged 60 and over. In half of the cases of grandparent caregivers, the child's parents were not in the household. One third (34.5%) of grandparent caregivers had been responsible for their grandchildren for 5 or more years.[4] (CSNA)

The 2001 National Children with Special Health Care Needs Survey found that 15.5% of Maine children aged birth to 17 years had special health care needs,[5] (CSNA) defined broadly as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[6] (CSNA) The corresponding proportion for the United States was 12.8%, which is significantly lower than that found in Maine.[5] (CSNA) The proportion of children with special health care needs in Maine increased with age, from 8.8% of 0-5 year olds to 16.2% of 6-11 year olds to 20.1% of 12-17 year olds. The US percentages for these age groups were 7.8%, 14.6%, and 15.8%, respectively. 23.5% of Maine households had one or more children under 18 years of age who had special health care needs, as compared

with 20.0% of households in the U.S.[6] (CSNA)

Women of childbearing age, defined as 15-44 years, represented 21.0% of the Maine population in 2002, which was similar to the US figure of 21.7%. The range across Maine counties was 18.4% to 22.4%. [1, 2] (CSNA)

Children under 18 years plus women of childbearing age together represented 40.5% of the Maine population in 2002, with a county range of 36.0% to 42.0%.[1] (CSNA)//2006//

Maine has sixteen counties of significantly varying sizes and population densities. Health care providers and infrastructure are distributed in direct relationship to population density. The largest, and one of the most sparsely populated counties, is Aroostook to the extreme north with 6,829 square miles, a population of 73,122 and only 73 primary care providers (physicians stating primary care as first specialty). These providers must serve a large, remote geographic area with essentially no major thoroughfares, limited resources, minimal support services, and hospitals designated as critical access only. In contrast, Cumberland County, one of the smaller and more densely populated counties to the south, has 1,217 square miles, a population of 269,083, 387 primary care providers (physicians stating primary care as first specialty) and an extensive network of surface streets and roads.

Maine has three major cities: Portland population 64,249 (+1.8 % from 1990-2000); Bangor population 31,473 (-9.0%); and Lewiston population 35,690 (-10.3%). However, Collectively the three largest cities account for only 10% of the state's residents. While 80% of American citizens reside in metropolitan areas, the majority of Maine's citizens continue to reside in rural towns and small cities that comprise the core of Maine's governmental structure.
Demographics

/2006/ The 2000 Census provided a snapshot of the racial and cultural diversity of Maine's population. (Note: Census data are for the entire state population, not just the MCH population.) In 2000, Maine was 96.9% white, with little variation across counties. Statewide, 0.7% of Mainers were Asian, 0.6% were American Indian or Alaska Native, 0.5% were black or African-American, 1.0% were two or more races and 0.2% described themselves as being some other race. Less than 1% of the entire population was Hispanic; 1.2% of children under age 18 were Hispanic. A much larger proportion of the entire population is French-American; on the 2003 Behavior Risk Factor Surveillance System (BRFSS) survey, 19% of Maine adults ages 18 and over reported that they were French-American or Franco-American.

While Maine's population is predominantly white, the state is very gradually becoming more racially diverse. The proportion of the population that is white decreased from 98.4% on the 1990 Census to 96.9% on the 2000 Census. Similarly, the proportion of Maine students in public and approved private schools who are white decreased from 97.5% in the 1993-1994 school year to 95.8% in the 2002-2003 school year.

The Census found that almost 3% of Mainers were foreign-born. Nearly 8% spoke a language other than English at home at least some of the time; the range across counties was 2.8% to 24.1%. Most of these people did also speak English. Two percent of people in the state reported speaking English less than very well.

The 2002 Maine Youth Drug and Alcohol Use Survey (MYDAUS) asked 6th-12th graders what language they used most often at home. 96.8% said English, 0.8% said Spanish, and 2.4% said "another language".

In the 2002-2003 school year, 77 languages other than English were spoken by school children in Maine. The nine most common languages spoken by Maine's "Limited English Proficient" (LEP) students in 2002 were French (spoken by 16.8% of LEP students), Spanish (12.9%), Passamaquoddy (10.7%), Somali (9.2%), Khmer (8.9%), Vietnamese (4.5%), Cantonese

(4.0%), Russian (3.7%), American Sign Language (3.4%), and Serbo-Croatian (2.8%). (Note: The National Clearinghouse for English Language Acquisition & Language Instruction Educational Programs' Web site glossary states that LEP refers to "students who have insufficient English to succeed in English-only classrooms.")

LEP students make up a small, but growing, proportion of Maine's school children. During the 2003-2004 school year, 1.6% of Maine students were LEP. This represented a 68.6% growth in LEP enrollment since the 1993-1994 school year; during this same time period, the total school enrollment in the state decreased by 10.9%.

"Culturally and linguistically diverse" (CLD) is another term used to describe diversity. The National Clearinghouse for English Language Acquisition and Language Instruction Educational Programs' Web site glossary states that the phrase refers to "individuals from homes and communities where English is not the primary language of communication, although the individual may be bilingual or a monolingual English speaker." While statewide statistics are not available, in October 2003, 25.4% of Portland's public school students were CLD; the school-specific proportions ranged from 0.0% to 62.3%.

Statewide in 2000, 0.5% of Maine children 5-17 years old lived in linguistically isolated households, defined as households in which all members aged 14 years and older speak a non-English language and also speak English less than very well. The highest concentration (6.7%) of children in linguistically isolated households was found in the Madawaska primary care service area in Aroostook County.

Beginning around 2001, the number of people with Somali ancestry living in Maine began to steadily increase. People from Somalia who were assigned to Maine through the Refugee Resettlement Program found the size and safety of the communities in Maine and the values of Maine communities were compatible with the values of the communities they left behind in Somalia. Word spread through the network of Somali people in other parts of the United States resulting in an in-migration of people of Somali ancestry from other parts of the United States. Initially Maine's largest cities of Portland and Lewiston were not prepared to provide services of the magnitude needed by Maine's newest residents. The initial year or so had some rough waters; however over the past 2-3 years the capacity to provide more culturally appropriate services has grown and the dialogue about expanding services and resources has been positive.

The availability of interpreter and translation services has increased since 2000, with the greatest growth in capacity being in Portland and Lewiston, two of our largest cities. Public Health Nursing (one of the Title V programs) uses a combination of individual translators and a language phone line. The other Title V programs rely primarily upon language phone line translators.

The former Department of Behavioral and Developmental Services provides staff to the Refugee and Immigrant Mental Health Committee. The committee is comprised of representatives from state government, local government (Portland and Lewiston), refugee and immigrant community, and social services agencies, primarily local agencies. In FY05 the Title V Director was invited to speak to the committee about Title V and Family Health. This resulted in an invitation as a permanent participant in the committee. The committee meets monthly in Portland. //2006//

Current Socioeconomic Indicators

/2006/ Maine's three largest sources of private sector revenue are tourism, healthcare and paper manufacturing (Maine State Planning Office). Maine's Bureau of Labor reports that farming accounted for approximately 2% of total resident employment in Maine in 2004. There was an average of 613,900 non-farm wage and salary jobs in 2004. Non-farm wage and salary

jobs were distributed as follows: natural resources and mining, 0.4%; construction, 5%; manufacturing, 10.3%; wholesale trade, 3.5%; retail trade, 14.3%; transportation, warehousing, and utilities, 2.7%; information, 1.9%; financial activities, 5.7%; services, 39.2%, and government, 17.1%.

At the time of the 2000 Census, 79.2% of Maine women ages 22-44 were in the labor force; 3.9% of these women were unemployed. The corresponding figures for the United States were 73.4% and 5.4%. The proportion of women ages 22-44 who were in the labor force ranged from 72.7% to 81.9% across Maine counties. The county-specific proportion of women in the labor force who were unemployed ranged from 2.8% to 7.8%.[96] (CSNA) The average unemployment rate for Mainers (male and female combined) in 2003 was 5.1%.

65.4% of Maine children under 6 years had all parents in the family in the labor force in 1999, as did 74.3% of 6-17 year olds. Both proportions are higher than that found in the United States as a whole (58.6% and 67.4%, respectively). The county-specific range for children under 6 was 58.0% to 73.4%; for 6-17 year olds, the county-specific figures ranged from 67.6% to 79.1%.[97] (CSNA)

Maine women ages 18-64 with disabilities are less likely to be employed than are women in the same age range who do not have disabilities. The 2000 Census found that 44.6% of women with a sensory disability, 30.7% of women with physical disabilities, 28.4% of women with mental disabilities, 18.4% of women with self-care disabilities, 31.7% of women with go-outside-home disabilities, and 56.7% of women with employment disabilities were employed. The employment rates for Maine women ages 18-64 without each of these disabilities ranged from 72.3% to 75.2%.98-[103] (CSNA) Maine has not yet met the Healthy People 2010 goal to eliminate disparities in employment rates between working-age people with and without disabilities.[104] (CSNA)

Statewide in 1999, 16.2% of children under 5 years were below the federal poverty level, as were 12.9% of children 5-17, and 10.0% of individuals ages 18-64.[105] (CSNA) The comparable percentages in 1989 were 15.7%, 13.1%, and 8.9%, respectively.[106] (CSNA)

Looking at families in 1999, 16.0% of families with related children under 5 years of age were below the poverty level in Maine; the comparable figure for families with children under 18 years was 11.9%. A third (36.4%) of families with a female householder, no husband present, and related children under age 18 were below the poverty level; that figure rises to half (54.7%) of such families with children under age 5.[3] (CSNA)

A third (32.8%) of Maine students were eligible for free or reduced school lunches in 2003 (Table 17).[107] (CSNA)

There is considerable variation in poverty and income measures across Maine counties For example, the county-specific proportions of children under age 5 who are below the federal poverty level range from 10.5% to 25.2%.

The Maine Center for Economic Policy has calculated estimates of what Maine families need to earn to make ends meet in today's marketplace. This "livable wage" is based on a basic needs budget that takes into account actual living expenses, including housing, health care, child care, transportation, and taxes. The livable wage is considerably higher than both the federal poverty level and the income of a minimum wage earner. The federal poverty level for a family of four in 2002 was $18,100. The annual income required for a 2-parent (2-earner) 2-child Maine family to meet a basic needs budget, in contrast, was $44,964, or 248% of the federal poverty level. The county-specific livable wage for this type of family was $41,207 to $50,111, or 228% to 277% of the federal poverty level. [110] (CSNA) As such, while significant portions of the MCH population are under the federal poverty level, even higher proportions are in families that do not earn livable wages.

The Maine Development Foundation reported in 2004 that for the past 8 years only about 66% of jobs in Maine had paid a livable wage.[108] (CSNA)

Homelessness has increased significantly in Maine in recent years. It is estimated that in 2002 about 1,200 people were homeless in the state on any given night; 400-500 of these individuals were children. Over the course of a year, nearly 10,000 people spend time in homeless shelters; about 12% of these individuals meet the federal definition of chronic or long-term homelessness. In March 2002, people who were chronically homeless used as much as 70% of shelter resources in the state. Maine State Housing Authority data for July 2002 showed that 36% of people seeking shelter were female and 28% were under 18 years of age. Over half of shelter guests had substance abuse issues, but only 16% were currently receiving substance abuse services. A third (33%) of homeless individuals had serious mental illnesses; 40% had dual substance abuse and mental illness diagnoses.[112] (CSNA)

The Maine State Housing Authority has identified five primary factors that contribute to the increasing level of homelessness in the state: (1) tight housing market and lack of affordable housing and supportive housing; (2) lack of access to mainstream housing and services resources by people who are homeless; (3) lack of state- and local-level coordination, planning, and progress measurement; (4) reduced availability of federal resources to fund homeless and affordable housing, and (5) inadequate wages that do not keep pace with overall housing costs.[112] (CSNA)

In 2002, housing resources for homeless people in Maine included 699 shelter beds for individuals, 356 shelter beds for families, 781 transitional housing units for individuals, 415 transitional housing units for families, 820 permanent supportive housing units for individuals, and 124 permanent supportive housing units for families. There are, however, gaps in program capacity. Shelters are sometimes completely filled and available beds are not always located within a reasonable distance of where homeless individuals are. As of 2002, 861 additional transitional housing units for individuals were needed, as were 994 transitional housing units for families, 621 permanent supportive housing units for individuals, and 640 permanent supportive housing units for families.[112] (CSNA) //2006//

Health Disparities

The majority of states have traditionally reported health disparities as health status differences between Blacks (African Americans) and Whites (Caucasians). In Maine our statistics don't show this ethnic disparity, probably because there is statistical insensitivity to the small numbers of Black residents in Maine. Maine's disparities are correlated with differences in education, income and low population densities of our rural areas. As part of Healthy Maine 2010 the Bureau of Health (BOH) is looking at seven factors that may lead to health disparities in Maine: 1) race and ethnic background 2) sexual orientation (gay, lesbian, bisexual, transgender) 3) socioeconomic status (low income/less education) 4) disability 5) geography (urban versus rural) 6) gender and 7) age. The Bureau of Health in conjunction with the University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Public Sector Innovation worked together to define the collection and reporting of data by race and ethnicity in response to federal OMB-15.
/2006/ The result of this work was to include the following racial categories on various BOH forms: White, Black/African-American, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and Other. Ethnic categories include Hispanic and given the state's large Franco-American population the workgroup recommended that the BOH pilot "Franco-American" as an ethnicity option on forms and surveys. Pilots were conducted through the "Maine Child Health" 5th grade survey and the BRFSS. An analysis of the BRFSS pilot is currently underway to determine potential relationships and correlations with health outcomes. //2006//

Current Political Climate

In 1996 Maine's Bureau of Health (BOH) was restructured in response to a mandate from the legislature to reduce the number of divisions within all State Bureaus. Significant administrative and leadership changes accompanied this reorganization. In 2000 the departure of Randy Schwartz, Director of the Division of Community & Family Health, resulted in another reorganization. The large DCFH was reconfigured into two smaller divisions: Division of Family Health (DFH) and Division of Community Health (DCH). This was not accompanied by major changes in leadership.

During this same time period, national trends regarding the role of state public health organizations have continued to shift toward a strong emphasis on states assuming responsibility for the core public health functions of assessment, assurance, and policy development. States such as Maine, without sufficient infrastructure to delegate direct services, find themselves assuming the dual role of carrying out core public health functions and providing and/or purchasing community-based direct services.

During the 1995 to 2002 administration of Governor Angus King there was significant support for issues of concern for the MCH population. Activities including the formation of the Children's Cabinet, support for SCHIP and dedication of State awarded tobacco settlement funds to public health illustrate this commitment. As with any change in administration there was concern there would be a loss of support for MCH related issues. Fortunately this did not occur.

John Elias Baldacci was elected Governor in November 2002 and is the first Democratic Governor in 16 years. The Democratic Party also won leadership of the Maine House and Senate. In the 2004 elections, the Democratic Party retained leadership of the Maine House and Senate. Maine's congressional delegation remains divided among the Republican and Democratic Parties. Olympia Snowe (R) and Susan Collins (R) represent Maine in the Senate and Thomas Allen (D) and Michael Michaud (D) in the House.

/2006/ In 2002, during the gubernatorial election, now Governor John E. Baldacci promised to merge the Departments of Human Services and Behavioral and Developmental Services and to significantly change the structure and culture. Effective July 1, 2004 the new Department of Health and Human Services (DHHS) was mandated to improve services, increase efficiencies, and improve relations with community organizations. The improvement in services, efficiencies, and relations apply to all segments of DHHS from direct and purchased service sections to finance and operations sections. During FY05, the Department focused on determining the new organizational structure that would best achieve the statutory mandates listed above. The Legislature approved the plan submitted by Commissioner Nicholas. (See Organizational Structure Section III C) John R. Nicholas was confirmed Commissioner of DHHS in April 2004. //2006//

Maine continues to be challenged economically but nowhere is it more ubiquitous than with our Native American population, some of Maine's poorest residents. The Penobscot and Passamaquoddy tribes had hope for improving their economic status in a referendum put before the citizens of the state in November 2003 that would allow the construction of a casino in the states southern most county. If approved, a casino was projected to bring thousands of jobs to the state as well as an estimated $50 million annually to the tribes. More importantly, the tribes hoped it would bring self-reliance. The tribes also had plans to market, through the casino, Indian Guide services for fishing expeditions on the Penobscot River since the removal of 2 dams on the river would attract sport fishermen.

Their vision was shattered when the referendum was soundly defeated. The tribes perceived this to be a vote against them by not allowing self-reliance and sovereignty. Voters did approve another gambling initiative that did not include the tribes, the development of racinos that would allow slot machines at horse racing tracks.

/2006/ Since November 2003 little progress has been made on potential economic sources of independence. In March of 2005 hope of a liquefied natural gas terminal on tribal land was lost

when the local community voted against the terminal. //2006//

Impact of Welfare Reform on Women and Children

The advent of Title XXI, SCHIP in 1997 instigated changes in insurance coverage in Maine. Maine responded by expanding Medicaid and by creating CubCare, a Medicaid-like Child Health Insurance Program (CHIP). This state operated insurance program for children, which includes EPSDT, was for ages birth through 18 years in families between 133% and 185% of the federal poverty level. In October 1999 the eligibility level was increased to 200% FPL. There is some cost-sharing for the CubCare Program. Outreach activities have resulted in an increase in Medicaid enrollment to a current maximum of approximately 162,000. There are 27.5% (82,415) children ages 0-17 participating in Medicaid. Expansion of Medicaid and CubCare not-withstanding, there are still serious concerns about the changing composition of our uninsured populations. In addition to the traditional numbers of uninsured working poor, there is a growing number of middle-income earners who cannot afford the escalating cost of premium co-pays required for dependent coverage. During the first session of the 120th Legislature, the name of the public insurance programs (i.e. Medicaid, CubCare, etc.) was changed to MaineCare. The name change went into effect in 2002.

Maine, like so many other states in FY04, continues to experience a decrease in state revenues resulting in a state budget shortfall. The most recent cuts have directly impacted service areas, particularly those purchased through the State Medicaid Agency. While enrollment and eligibility for MaineCare services have not been reduced, some services have been limited along with reductions in provider fees.

Statewide Health Care Delivery System (County & Local Health Departments)

Maine's rural nature and town meeting format of local government essentially preclude any significant County government structure or influence. The two largest cities maintain local health departments, however, there are no other health departments in Maine. Most public health functions are concentrated at the state level with minimal staffing and funding. The absence of local health departments and county government is further complicated by issues of uneven provider distribution, economic disparity, and a large rural population. All these challenges require the Bureau of Health to provide some direct services in order to ensure statewide public health services access for our most vulnerable populations. The State's capacity to perform many categorical public health functions is extended through contracts with private health agencies; i.e. home health agencies; hospitals; rural health centers; and private physicians. Access is augmented by a developing telemedicine system statewide both in the areas of physical and mental health services. Hospitals and health centers particularly in the northern portion of the state are beginning to connect with specialists and tertiary care centers for consultation.

Through Public Health Emergency Preparedness (PHEP) efforts and activities related to the Maine Turning Points Project, the Bureau of Health and its' public health partners continue to focus on strengthening public health functions at the local level. Legislation to develop regional public health areas was withdrawn pending an assessment of its' fit with the Governor's proposed health plan. Establishment of regional epidemiology teams occurred through the state's PHEP activities, with the state divided into six (6) regions that align with the Emergency Medical Services (EMS) regions.

The Governor's Office of Health Policy and Finance (GOHPF) is leading the development of Dirigo Health, legislation passed at the end of the first session of the 121st Legislature. (Final legislation is included in the Appendix). A major component of the legislation is the creation of a Health Insurance Program that includes health promotion, disease management, quality initiatives and health coverage through private insurance carriers that individuals, self-employed, and small businesses can buy into. Eligibility for enrollment will expand over five years with the projection that all Mainers will have access to health insurance by 2009. Other key components include costs and quality. Dirigo Health will work with hospitals, doctors, patients, businesses and insurance companies in an effort to control rising health care costs to ensure that all Maine people have the health care they need at an

affordable cost.

The Bureau of Health is involved in the Maine Quality Forum (MQF) represented by Bureau Director, Dr. Dora Anne Mills and has a significant responsibility in the review of and recommendations regarding Certificate of Need (CON) requests. In addition the MQF will collect and disseminate research, and promote evidence based medicine and best practices.
/2006/ Anthem Blue Cross and Blue Shield won the award to provide the health benefit package for Dirigo Health. Enrollment in the Dirigo Health Insurance Plan started January 1, 2005. As of June 1, 2005 enrollment in Dirigo, including dependents was 7,311. Of those 2,925 are small business employees, 2,525 are self-employed individuals, and 1,861 are individuals who are unemployed or do not receive coverage through their employer. //2006//

Primary Care

Maine has two primary referral centers for health care needs: Maine Medical Center in Portland and Eastern Maine Medical Center in Bangor. In addition there are 36 acute care hospitals (33 are birth hospitals with obstetrical services); 12 critical access hospitals; 17 Federally Qualified Health Centers (FQHC); 1 FQHC Look-a-like (St. Mary's in Lewiston) and 50 community health centers; 5 Indian Health Service funded health centers (3 on Reservations, 1 in Presque Isle, 1 in Houlton); and one osteopathic medical school. There are no allopathic medical schools in Maine.

Prenatal Care

Efforts to improve maternal and infant status in Maine are complicated by our geography and population distribution. Multiple services are available locally prior to the occurrence of a normal pregnancy and continue through the postpartum period for women and through the first year for infants. However, our high-risk services are located in our three largest cities: Portland, Bangor, and Lewiston. Level III Facilities are located in Portland and Bangor. A Level II facility is located in Lewiston. Women without insurance or documentation can access service through a free-care pool of providers and monies. The Genetics Program manages a grant with Maine Medical Center for the provision of perinatal outreach, which includes education of providers and consumers regarding issues pertinent to pregnancy outcomes. Historically a greater proportion of Maine women (between 86 and 89%) receive prenatal care during the 1st trimester. Besides routine clinical checks, Maine women receive additional pre-natal education. The Partnership for A Tobacco-free Maine is aggressively addressing smoking cessation among pregnant women and the 2000 PRAMS has added a smoking question to begin capturing data on this issue. There has been a decrease in the number of women who report drinking alcohol during pregnancy. In 1990 11% reported consuming alcohol while pregnant and in 2002, 5% reported drinking alcohol during the last 3 months of pregnancy. (PRAMS data). We are hoping this is a reflection of increased education and awareness among patients, providers and staff who interface with pregnant women and new mothers.

High-Risk Care

A small portion of the states MCH funds support the 24-hour statewide availability of perinatology and neonatology consults for providers. Great care is taken to transport high-risk pregnant mothers to the appropriate facility prior to delivery. However, in the event this is not possible, or an infant is born with unexpected complications, both Level III facilities facilitate transport via provision of a specially trained and equipped neonatal transport team utilizing both air and ground transport. The Level III nursery in Bangor recently had a significant reduction in the number of neonatal nurse practitioners working in their Neonatal Intensive Care Unit (NICU). Their perinatologist has also been called to active duty. The hospital is taking steps to rebuild its capacity, however, in the meantime providers will rely more heavily upon the resources of the Level III nursery in Portland. The Level II nursery in Lewiston has notified area hospitals that, with the departure of one of their neonatologists, it can no longer care for infants at less than 32 weeks gestation.
/2006/ Eastern Maine Medical Center, Level III Nursery in Bangor is gradually recovering from staffing changes through recruitment of nurses and neonatal Nurse Practitioners. An

experienced Neonatologist is expected to join the staff in July 2005. The Central Maine Medical Center in Lewiston continues to limit its scope to pregnant women and neonates beyond 32 weeks gestation. //2006//

Birth Defects

The Maine Genetics Program established a CDC Cooperative Agreement to develop and implement a state-based birth defects surveillance program starting in 1999. Rules for the Birth Defects Program (BDP) were promulgated in early 2003 and became effective May 1, 2003. In collaboration with the University of Maine, Orono a database and tracking system, ChildLINK, was developed and can be used by both the BDP and the Newborn Hearing Program (NHP).

/2006/ Abstraction of medical records for the BDP started in August 2003. Use of the ChildLink database and tracking system for both BDP and NHP began implementation in March 2004 with the first hospital, Eastern Maine Medical Center in Bangor, beginning to report hearing screening results directly into the online database system. Once all birth hospitals are enrolled for reporting in July 2005, the database and tracking system will be fully functional. The percentage of newborns screened for metabolic and endocrine disorders, and hemoglobinapathies average 99.6 -- 99.9% annually. The percentage of newborns screened for hearing loss at discharge has increased to 90%. //2006//

Pediatric Services

Pediatric services are provided by pediatric and family practice physicians as well as pediatric and family nurse practitioners and physician assistants. There are 963 Certified Nurse Practitioners in Maine but the Board of Nursing is unable to report on practice location. We estimate that 94% of our children now have insurance. Because of this, we phased out the PHN Well Child Clinics and are encouraging the connection of children to a pediatric medical home . Title V funds focus on specialty or "wrap-around" services (e.g. pre-delivery genetic testing and post-delivery genetic counseling, or the services of a pediatric specialist (e.g. pediatric endocrinologist). Implementation of prior authorization for pediatric medications paid for by MaineCare began in late 2003. Initial implementation of prior authorization was burdensome to pediatric providers. The Division of Family Health acted as liaison between providers and MaineCare to articulate the issues and develop resolutions that were amenable to all parties.
/2006/ A recent challenge to heath care services for all populations insured through MaineCare has been reimbursement for services provided. The Bureau of Medical Services (State Medicaid Agency) transitioned to a Client Management Information System beginning in January 2005. The new system is HIPAA compliant and requires more detailed billing information than with the prior system. This has resulted in the rejection of numerous claims from service providers. The problems are gradually being resolved though many service providers/agencies remain in a precarious financial situation until all issues are resolved.

CSHCN Services

In FY03 2,087 infants, children, and youth were served by the CSHN Program. The Department of Education, Division of Special Services, reported for school year ending June 2003 that 37,784 children ages 5 - 21 were served by special education services; an additional 1,078 children ages 0-2 years (Part C), and 4,482 children ages 3-5 years (Part B) were served by Child Development Services, a total of 45,431 infants, children and youth.
/2006/ In FY04 2,000 infants, children and youth were served directly by the CSHN Program. The Department of Education, Division of Special Services, reported for the school year ending June 2004 that 37,573 children ages 5 -- 21 were served by special education services. This is a decline of 211 students and is due, in part, to the decline of regular education students. 1,064 children ages 0-2 (Part C) were served. //2006//

Maine's Access to Dental Care

Thirty-nine of Maine's 46 Dental Care Analysis Areas are designated as Dental Health Professional Shortage Areas (30 are population designations, including two Indian reservations, 9 are service area designations) along with the two state-administered mental health facilities in Augusta and Bangor. Although newer figures are not available, all indications are that the resident to dentist ratios in 11 of the 16 counties remain substandard to the state average. As noted, fewer than half of Maine's practicing dentists treat MaineCare patients but also, relatively few will accept new MaineCare patients (estimates vary from less than 20 to almost 40 in any given month). It is also worth noting that many dental practices in Maine are apparently at or close to capacity, and many individuals, regardless of their insurance or financial status, report difficulty in finding a dentist who is accepting new patients. In certain areas of the state, timely access to services continues to be of great concern.

Efforts to improve access to dental services in Maine have continued through various channels. The OHP has continued its support of the statewide Maine Dental Access Coalition, which continues to function as network and constituency for oral health. The Dental Services Development and Subsidy Program, authorized by the Legislature in 2001 to fund a capacity-building competitive grants program and a subsidy program for community-based dental clinics, continues to have strong support legislatively. During FY2003, there were 18 grants to 16 agencies for a variety of capacity-building initiatives, and 11 agencies participated in the subsidy program. Through a second round of competitive grants in the Dental Service Development Program, 10 additional agencies received funding. Eight grants for development and expansion and two for case management and community education. The grants will include three budget periods, one through June 30, 2004 and the others for the succeeding state fiscal years, terminating on June 30, 2006.

Mental Health Services

/2006/ Traditionally the Department of Behavioral and Developmental Services (BDS) had responsibility for leadership for mental health in the state. The creation of the new DHHS in July 2004 opened up a myriad of possibilities for the Title V and Mental Health Agencies to unite in leadership to strengthen the systems and policies to support healthy emotional and cognitive development for all children and families. Mental health services (including substance abuse services) are divided into two populations, adult and children. These are being integrated with other services provided to those populations for a more effective and efficient delivery of services. New opportunities that have already emerged during the past year include:

1. The strong emphasis in the Humane Systems for Early Childhood Grant on social and emotional health. The Task Force on Early Childhood has an action team that specifically addresses how the state early childhood plan will recommend action steps to humanize and de-stigmatize our approach as a state to this issue.
2. Collaboration between Children's Behavioral Services (formerly BDS) and Title V on systems issues such as transition from youth to adulthood of people with special health needs and vulnerable groups such as high-risk youth who have "fallen through the cracks".
3. Continued efforts, particularly through a Healthy Tomorrows Grant for a Behavioral and Developmental Clinic in York County and a Maine Health Access Foundation Grant to Kennebec Valley Mental Health, to integrate mental health into primary health care systems for the MCH population.
4. Continued involvement of Title V leadership in a SAMHSA grant to strengthen state and local mental health systems as they relate to emergency preparedness.
5. Continued involvement of Title V leadership with efforts to strengthen systems of care for children affected by trauma. Such involvement included participation in a statewide conference in May 2005 on the relationship between adverse childhood experiences (ACE) and adult morbidity and mortality.
6. A new project, led by the Maine AAP and the Bureau of Health, to raise awareness and change the role of physicians in schools so that they become engaged as leaders in collaboration to address school health issues that relate to social and emotional

development. //2006//

The purpose of public health, as defined by the Institute of Medicine, is to foster conditions that will enable the whole population to achieve optimal health. At the center of public health is the human mind and spirit. The Maine Title V Program views the mental and spiritual health of children and families within the context of our five global priority areas as outlined in Section IV B of this application. We continue to sharpen and increase our focus on issues involving the mental health and primary health care systems.

Despite a significant growth in the number of licensed clinicians and psychiatrists in Maine, the need continues to outstrip demand. Primary care physicians are left picking up the slack, and they have to deal with a complex system with a history of less than optimal communication and collaboration. In recent years, the former Department of Behavioral and Developmental Services (BDS) has embarked on a search to explore new and innovative means of addressing the challenges. The Maine Title V Program has been a partner in this search with child and adult mental health since 2003.

A promising model that we want to put into practice in Maine is an integrated system of primary care and mental health. While still relatively new, this system has been successfully implemented in other states. Although its details vary according to the unique needs and strengths of communities, the model views the primary care physician as the primary source of mental health care and focuses on developing a link between the child's medical home and their mental care system.

In 2001, at a meeting of the Public Health Committee of the Maine Medical Association, facilitated by Bureau of Health Director Dr. Dora Mills, physicians identified mental health services as a pressing public health concern. In 2002, the former BDS joined with the Maine Center for Public Health (MCPH) to continue this dialogue. In 2003, the MCPH, with strong support and involvement by the MCH Medical Director, received a planning grant from the Maine Health Access Foundation. The intent of the grant, conducted in partnership with BDS, Maine Medicaid, and the Bureau of Health, was to develop evidence-based integrated practice models that would be tested in a subsequent two-year applied research project. We hope that testing the models at a small number of sites will lead us to understand what works and what doesn't. The model can serve as a strategy for the state as a whole.
/2006/ The planning grant ended in 2004. The Maine Health Access Foundation did not express interest in a follow-up system of care grant so the grant expired. BDS (now Children's Behavioral Health Services in the new DHHS) has not taken any active steps to address this important issue. At this time, however, there are about 25 sites around the state that are utilizing varying degrees of integration, and a number are studying outcomes. Also, the Department, including Title V, continues to strongly support integration and, in particular, Ed Wagner's "Care Model" out of Washington State. //2006//

The MCH Medical Director's leadership has helped to identify and recruit a group of Maine pediatric practices that are ripe for testing the models; made sure that the efforts of the State Early Childhood Comprehensive Systems Grant are connected with those of the project; advocated strongly for family and community involvement in all phases of the project; and joined in a panel on public policy at a statewide conference on mental health and primary health care in June 2004

B. AGENCY CAPACITY

Our many partnerships and collaborations expand our capacity to ensure good penetration of services in all but the most northern area of our state and a few other remote pockets where we continue to be challenged by difficult access to care. The goal of both the Division of Family Health and the Division of Community Health is to collaboratively promote health and prevent disease, injury and disability through a variety of cross programmatic public health interventions ranging from primary prevention through broad-based community health promotion initiatives, early detection, health systems interventions, delivery of health services and the promotion of healthy public policies. The vision is "that individuals, families and communities in Maine will achieve and sustain optimal health and

quality of life" through:
1 Building systems and community capacities
2 Initiating and advocating for public health policy
3 Developing and delivering programs and services
4 Collaborating with others
5 Providing leadership

Maine Department of Human Services, Division of Community and Family Health (1997) and Family Health (1999), Vision Statement.

We are part of an ongoing national trend to re-evaluate the role of public health policy and programs in state systems and infrastructure. We use the five-year planning process as an opportunity to reassess our overall direction. Because we must continue to be the "safety net," and provide direct services for some of our most vulnerable residents, changes in program focus and activities must be done with great care and forethought. This is a multi-year process, requiring transitioning of resource allocations from traditional to current and emerging priorities. Continued collaboration with stakeholders and representative advisory groups is critical.

Strong relationships with organizations, in particular the Muskie School of the University of Southern Maine (USM); University of Maine at Orono; Medical Care Development; and the Maine Center for Public Health are critical to our programs success. These organizations not only provide manpower but also make available critical expertise on issues important to Mainers. The Muskie School, specifically the Institute for Public Sector Innovation representations, have also provided guidance and education regarding strategic planning and coalition building, skills essential to a healthy Title V program.

/2006/ For several years the Division of Family Health has worked to increase our MCH epidemiology capacity. The State Systems Development Initiative (SSDI) grant was restructured during fiscal year 2000 to provide partial support for the salary of a Masters prepared Epidemiologist specific to MCH. The SSDI funds were pooled with funds from the Childhood Lead Poisoning Prevention and Asthma Programs to hire a full-time Masters prepared Epidemiologist (Kathy Tippy, MPH), who began in December 2000. During the summer of 2000, the Title V Director worked with Dr. Sonnenfeld, Chronic Disease Epidemiologist at the time, in developing an application for a grant from the Council of State and Territorial Epidemiologists (CSTE) to support the hiring of a PhD prepared Epidemiologist for MCH. The application was approved and in the spring of 2002 Dr. David Ehrenkrantz, PhD in Public Health Administration, was hired as the MCH Epidemiologist. Dr. Ehrenkrantz resigned the position in April of 2004. In July 2004 a second Masters prepared epidemiologist was hired (Cindy Mervis, MPH), bringing the Epi Team to a total of 3 staff. A year long search resulted in the hire of Dr. Erika Lichter as the new PhD prepared MCH Epidemiologist, bringing the Epi Team to a total of 4 Epidemiologists as of June 2005. Also in 2004, the Title V Program was successful in obtaining an MCH Epidemiology Fellow, Meredith Anderson, MPH, for a two-year fellowship through the CDC and CSTE.

In the spring of 2004 the Childhood Lead Poisoning Prevention Program (CLPPP) organizationally moved from the Division of Family Health to the Environmental Health Unit (EHU). The EHU monitors and provides technical assistance in the area of adult lead poisoning. It was determined synergies would be gained by connecting CLPPP with EHU. The CLPPP Director attends the monthly Title V Program Manager meetings and meets quarterly with the MCH Medical Director and the Title V Director. To date this relationship has proven effective in maintaining collaboration and coordination of the CLPPP with the Title V Program. //2006//

C. ORGANIZATIONAL STRUCTURE

The State Title V Agency in Maine is the Maine Department of Health and Human Services (DHHS). Administrative oversight of the Maternal and Child Health Services Block Grant is vested with DHHS's Bureau of Health (BOH).

Programs, which focus primarily on the MCH population, are found in both the Division of Family Health (DFH) and the Division of Community Health (DCH). The day-to-day management of the MCH Block Grant is carried out in the Division of Family Health, with Valerie Ricker designated as the manager with ultimate responsibility for administration of the MCH Block Grant. The Childhood Lead Poisoning Prevention Program (CLPPP) organizationally relocated to the Environmental Health Unit (EHU). Over the years the CLPPP and EHU had increasing programmatic interests which led to a greater understanding of the synergies that could be achieved with augmented day to day integration of the programs. The CLPP Program Manager will continue to participate in the monthly MCH Program Manager meetings and will meet, at least quarterly, with the Title V Director and the MCH Medical Director.

John R. Nicholas, Commissioner of Maine's Department of Health and Human Services, reports directly to Governor John E. Baldacci. Dora Anne Mills, M.D., M.P.H. serves as Director of the Bureau of Health (BOH) and State Health Officer. Commissioner Nicholas reports directly to Governor Baldacci. He is responsible for implementing the merger of the Departments of Human Services and Behavioral and Developmental Services into the new Department of Health and Human Services. Dr. Dora Anne Mills reports to Deputy Commissioner of Health, Integrated Access and Strategy, J. Michael Hall. Ms. Ricker reports to Dr. Mills. Valerie Ricker, M.S.N., M.S. is Director of the BOH's Division of Family Health which houses primarily direct service programs. Barbara Leonard, M.P.H. is the Director of the BOH's Division of Community Health that houses population-based prevention and health promotion services. Richard Aronson, M.D., MPH, is the MCH Medical Director. We have 2 MCH epidemiologists, Kathy Tippy, MPH and Erika Lichter, PhD.
/2006/ The Division of Family Health continues to support a Women's Health Coordinator position in an effort to focus attention on womens's health in a more comprehensive manner. //2006//

Maine's remote location and salaries that are non-competitive with neighboring state's urban areas continue to pose recruiting challenges for the Department.
/2006/ Ongoing shortfalls in the state budget pose difficulty in hiring into state positions. Federally funded positions are less difficult to gain approval to fill. //2006//

The MCH leadership has clinical training and expertise. They maintain membership with their respective professional organizations i.e. Maine Nurse Practitioner Association, Maine Chapter of American Academy of Pediatrics, and North East Rural Pediatric Association ensuring an ongoing relationship with primary care providers. Several MCH personnel are also involved in statewide and national initiatives that involve primary care.

Organizational charts indicating positions and/or programs supported with Title V funds are attached.

D. OTHER MCH CAPACITY

The majority of the MCH Title V program staff are centrally located in Augusta, our State Capital. Staff classifications include: clerical support, health planners, planning and research assistants, health educators, program managers, accountants, and MCH medical director and administrative senior managers. Title V also funds 5 positions outside the Divisions of Family Health (DFH) and Community Health (DCH): one person in the Office of Data, Research & Vital Statistics (ODRVS); 2 in the Health & Environmental Testing Laboratory (support lead testing, sexually transmitted disease testing, etc.); and 2 in the Department of Education (work with schools to develop and utilize comprehensive health education curriculums). All of these positions contribute to the achievement of MCH priorities. Parents of children with special health needs form the leadership and body of the Family Advisory Council

(FAC). Youth with special health needs are the body of the Young Educators and Advocators of Maine (YEA ME) advisory with staffing provided by the Children with Special Health Needs (CSHN) Director. No staff has been hired because they are parents of CSHN although several staff members do have children with special health needs. The CSHN Program also contracts with a parent consultant to provide peer support to parents/families receiving services through the Southern Maine Metabolism Clinic.

ODRVS provide data for this grant application, attend the Maternal and Child Health Block Grant (MCHBG) review session, and meet with the Epi Team and DFH managers for specific data needs. Our increased epidemiology capacity is leading to increased cross-divisional work between Bureau of Health (BOH) and ODRVS on MCH priorities. Health & Environmental Testing Laboratory staff meets regularly with the Lead Poisoning Prevention program staff and also the STD/HIV (Sexually Transmitted Disease/HIV) staff. The Department of Education (DOE)works closely with the Manager of the Coordinated School Health Program, to develop and use comprehensive health education curriculums that include sexual health. We believe that by facilitating the development of citizens who understand their bodies and take ownership of their health care we have lowered our teen pregnancy rates, increased abstinence and decreased the incidence of sexually transmitted diseases. Through SSDI, Council of State and Territorial Epidemiologists (CSTE) and other categorical funds we have increased our epidemiology capacity. Our epidemiologists have worked closely with the DOE and other public health partners to develop a survey with multiple health indicators that will help us monitor Maine's children's health status and develop a long term surveillance system within the BOH.
/2006/ The survey, called the Maine Child Health Survey (MCHS), has been administered by the Asthma Prevention and Control Program since its inception in 2002. During FY06 a plan will be developed to transition the MCHS to a more appropriate and permanent home. //2006//

/2004/ During the early 1990's support for many state funded positions was assumed by the MCHBG. A state budget deficit resulted in positions being cut if other funding sources could not be identified. Converting Public Health Nursing (PHN), Teen and Young Adult Health (TYAH), Maine Injury Prevention, CSHN and Oral Health positions to federal funds facilitated maintenance of staff providing services to the Title V population. In FY02 staff salaries exceeded available federal funds. A short-term alleviation included salary savings through vacancies and medical leave, freezing vacant lines and extensive reductions in purchased supplies and materials. Long-term remediation involves generation of revenue to support positions to be accomplished through fee-for-service and targeted case management.
/2006/Currently there are 13 vacancies within the programs serving the MCH population. The vacancies are within the Oral Health, Injury Prevention, Children with Special Health Needs, and Public Health Nursing Programs. The PHN Program has 9 field nurse vacancies and the Director of PHN is retiring July 1, 2005. Recruitment is ongoing for all vacant positions. Filling clinical positions such as PHN and Registered Dental Hygienist are particularly difficult due to low salary differences between state government and private sector.//2006//

In addition, Title V partially supports 56 Public Health Nurses (5 supervisors and 51 field nurses) who are based statewide in 17 regional satellite offices. These nurses provide direct services via home visits, school health, immunizations, well child and specialty clinics, and participate in our program planning/evaluation. The Title V Program also has an agreement with the University of Southern Maine's Muskie School of Public Service for assistance with facilitation, training, and performance measurement, and quality improvement activities.

Senior level management include: Valerie J. Ricker, Director of the Division of Family Health, which has administrative responsibility for Title V. Ms. Ricker has 25 years of experience in MCH, 9 years with the Maine Bureau of Health as Title V Director. She has a BSN and MSN in Nursing and MS in MCH, focusing on Public Health. Dr. Richard Aronson, MCH Medical Director, has 27 years of experience in State and Maternal Child Health Programs. Dr. Aronson is a trained Developmental Pediatrician. His previous positions were with Wisconsin and Vermont State Health Agencies. He assumed the MCH Medical Director position in August 2002. Toni Wall is the Director of the CSHN Program and has been in this position for 5 years. She has 16 years experience working in Bureau of

Health Programs prior to CSHN. Her past experience has prepared her to influence and manage the program. Toni holds a Masters in Public Administration with a concentration in Health Care Administration. Kathy Tippy has a Masters in Public Health with a concentration in Epidemiology. She brings 5 years experience of working in State and Local Programs. Kathy has been working with the Bureau of Health since December 2000.
/2006/ Dr. Erika Lichter joined the MCH Epidemiology Team in early June 2005. Dr. Lichter has a ScD in Public Health with a major in MCH and minors in Biostatistics and Epidemiology. Prior to coming to the BOH, Dr. Lichter taught at the Harvard University School of Public Health. Biographical Sketches are on file in the Bureau of Health's Division of Family Health and will be made available for review on request. //2006//

E. STATE AGENCY COORDINATION

The Bureau of Health, Division of Family Health (BOH/DFH) has several methods for establishing working relationships/collaboration with other entities. We make a concerted effort to establish personal contact with others we believe to be representatives of key stakeholders in issues that involve shared populations. Others approach us when they determine that we are stakeholders in their initiatives. Finally, we convene planning groups and ask for consensus on group membership and involvement. The work of the Task Force on Early Childhood through the Humane Systems grant is exponentially creating ripples of communication among state agencies, community partners, and families. Maine Title V has been responsible for:
- Creating a Task Force on Early Childhood of 120 varied state, community, and family representatives
- Developing comprehensive grant proposals for early childhood systems, women's health, integrated services for children with special health needs, and implementation grant for traumatic brain injury
- Sharing resources and ideas for survey development
- Connecting the Department of Labor with Child Care Resource Development Centers to meet MCH population needs for child care when seeking training or employment
- Leading ad hoc groups to study and report on the prevention of prematurity and, on early childhood as an economic development issue
- Engaging, with Dr. Aronson's involvement, the Maine Chapter of the American Academy of Pediatrics (AAP) participation in a family centered survey dealing with child care in the workplace
- Promoting interagency training, including cultural and linguistic competence, oral health, and assets
- Supporting the Maine Chapter of AAP in developing a website for their organization

The BOH/DFH continues to develop a relationship with Maine's primary care organization "Maine Primary Care Association". This organization has many competing priorities, and the former executive director did not identify MCH as a major area of focus. Their new director has experience working closely with MCH and we are anticipating an enhanced relationship with the association. The new Director, Kevin Lewis, formerly worked in Wisconsin as the Legislative Liaison for the Department of Health and Family Services. The current MCH Medical Director for Maine, who held a similar position in Wisconsin, worked closely with Mr. Lewis on a number of MCH related issues, including legislation for the Birth Defects Program. Dr. Aronson reconnected with Mr. Lewis in Maine, and they have already discussed collaboration on issues involving domestic violence, Native American health, and the fostering of primary care systems rooted in the principles of family-centered care, resiliency, and cultural and linguistic competence.

/2005/ The Women's Health Coordinator represents the Division of Family Health on the Maine Primary Care Association's Violence Against Women Governmental Affairs Planning Grant Committee. The DFH, in partnership with the Maine Primary Care Association and the Department of Behavioral and Developmental Services, submitted an application to the Maternal Child Health Bureau (MCHB) on a women's health grant in April 2004. The MCHB funding focused on three areas of women's health: development of comprehensive systems of services, obesity, and mental health. The DFH application focused upon the mental health area and was titled Women's Behavioral Health Systems Building: Innovative Ideas for Local and State Collaboration. Review of grants is scheduled for late June. If successful in our application this funding will assist us in continuing a focus on

women's health and create new partnerships for the Division and Bureau. //2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

/2004/ The Maine MCH Program is rooted in the vision that families, communities, and our state as a whole thrive when all children enjoy optimal health; feel physically and emotionally safe; are treated with dignity and respect; enter adulthood equipped with intense curiosity about the world, a deep desire to learn, a resilient spirit, and a healthy balance of cognitive and emotional skills; and have a sense of purpose, hope, and power about their lives, so that they can become compassionate and productive citizens. This vision reflects an underlying belief in the potential for communities as a whole to be healthy and for the core human values of dignity and respect to become the cornerstones for healthy children and families.
We strive in our Title V Program to design and put into practice humane systems that make it easier for Maine to fulfill this vision. Such systems foster the conditions for home and community environments to nurture children unconditionally; for childcare and education to provide safe and stimulating environments; for medical, dental, and mental health homes to be accessible, and to engage with families in a spirit of affirmation and partnership. Developing humane systems to improve the health and safety of the MCH population requires that we carefully identify and measure the outcomes that we want to see in the health status of Maine's children, families, and communities. Measurement requires information that is in thoughtful alignment with the strengths and needs of Maine's MCH population, and that has the potential to spark community and state level action.
How are Maine's children and families doing? Are they better off or worse off than they used to be? Which populations of children and families do well? Why? Which populations are most vulnerable to not doing well? Which populations experience health inequalities and disparities? Why?
We welcome the Health Systems Capacity Indicators because they help us to answer these questions and, in turn, to catalyze the kinds of creative systems and community wide changes that are most likely to improve the health and safety of Maine's children. The Health Systems Capacity Indicators also support Maine's public health plan for 2010 that includes a special supplement entitled HealthyMaine2010: Opportunities for All. This document (available at http://www.state.me.us/dhs/boh) identifies populations in Maine that face health inequalities and presents a compelling case for action to reduce these inequalities.

The following examples show how the Health Systems Capacity Indicators will help us to become clearer on how to connect data to action:

Indicator #1 - Asthma Hospitalization Rate in Young Children: Routine analysis of hospital discharge data gives us benchmarks in the determination of asthma morbidity among young children. It also reflects on the quality of and access to health care. The lack of a medical home and inappropriate asthma management are directly related to the increased probability of unnecessary hospitalizations. Asthmatic children unable to gain access to primary care or prescription medications due to uninsured or underinsured status are also at a greater risk of needing hospitalization. Hospitalization rates may vary according to geographic location and point to a disparity in access to ambulatory primary care between urban and rural communities. Not only are there direct costs associated with unnecessary asthma hospitalizations, but the indirect costs associated with lost parental work days along with the overall decrease in the quality of life are immeasurable. For these reasons, analyzing and reporting hospitalization data are crucial.

Indicator #5 -- Medicaid and Non-Medicaid Comparison. Maine has put a great deal of energy into expanding eligibility for Medicaid and simplifying the enrollment process. Medicaid now incorporates the Child Health Insurance Program (CHIP). It covers pregnant women and children birth through 18 up to 200% of the federal poverty level. To what extent does the Medicaid population differ from the non-Medicaid population with respect to low birth weight, infant mortality, and prenatal care? Although lower-income populations typically do not fare as well, we are eagerly interested in knowing if our MCH efforts such as home visitation, WIC, and Public Health Nursing may be reducing the magnitude

of the income disparity for maternal and infant health. Indicator #5 opens the door for such probing. It also challenges us to intensify our efforts to strengthen collaboration with the Medicaid Program.

Indeed, the process required for us to report on this indicator heightened our understanding of the complexity of Medicaid -- how, for example, the Medicaid population includes a heterogeneous mix of recipients who qualify through multiple categories; and how the way that Medicaid defines eligibility (one month versus 11 month enrollment in a given year) significantly affects the indicators. At the same time, by working together, Medicaid learns from us that Medicaid enrollment itself does not translate into full access to a Medical Home for a recipient; and that family-centered and culturally competent systems are essential to families feeling honored and respected when they seek preventive care. Also, the Medicaid-MCH dialogue bears fruit as we carefully watch for the impact of the nation's economic downturn and state fiscal crises on the health of the lower income population. To date Maine hasn't made cuts in eligibility levels or significant cuts in services, but we must anticipate potential changes in the future, and plan how to deal with them.

Collaboration is the highest form of working together. It involves not only coordinating and cooperating with each other but also sharing resources and capacity. Thus, the Health Systems Capacity Indicators serve the vital function of enriching the collaboration between Medicaid and MCH.

Indicator #9A -- General MCH Data Capacity: As MCH leaders, we can make sound decisions about our policies, strategies, and systems only if useful, clear, accurate, and timely information is available to us and to all of our partners -- including the families and communities that we serve. Maine's vision and passion for creating and sustaining healthy families in healthy communities must be fueled by public health information systems that grow out of culturally competent and family-centered organizations. Such systems are central to how we address Health Systems Capacity Indicator #9A: the ability of states to assure that the Title V Agency has access to policy and program relevant information and data. This directly supports the Infrastructure Building activities of the MCH Pyramid.

No single information source can fuel the complex multifaceted work of maternal and child health. Historically, we have collected information using single-purpose or program-specific databases, some of which were recorded on paper forms or charts; and we have typically not included families in designing, implementing, and evaluating such information. Computerized databases often constitute independent data "silos" from which data exchange is difficult and at times impossible. This significantly impairs the capacity of Title V, families, and communities to plan MCH efforts in thoughtful, inclusive, and visionary ways. We are challenged to make a major shift in the way we approach and use data, so that it is more reliable, family-centered, population and system based, and tailored to addressing health disparities.

The Bureau of Health, which houses the Title V MCH Program and is part of the Department of Health and Human Services, is in the process of developing an Integrated Public Health Information System (IPHIS). This web-based information system will consolidate the roughly 30 databases that reside in the Bureau of Health into a newly created Public Health Data Warehouse. The web-based system will format the databases so that they meet a core set of privacy and security standards established by the Centers for Disease Control and Prevention. The databases will be able to interact with each other in ways that lend themselves to in-depth analyses, dialogue, and action. The system will be able to link Bureau of Health databases from multiple sources such as Vital Records, WIC, and the Lead Poisoning Prevention Program. The system will be accessible to the Bureau of Health (and other state agencies per data sharing agreements) for public health assessment, program planning, and evaluation. The data repository will also feed information to a public web-based community health information system. This will be an independent and stand-alone system that provides up-to-date real-time comprehensive information on health status, quality of care, and population-based health outcomes. The Integrated Public Health Information System is expected to be fully designed by 2005 and fully operational by January 2008. As we address Health Systems Capacity Indicator #9A, it is critical that we work closely with the IPHIS staff.

/2006/ In response to Health Systems Indicator #9A, we plan to link WIC records to other data

bases, including infant birth and death certificates and hospital discharge data. This will strengthen our capacity to answer the following questions and take action accordingly: 1) What percentage of babies born in Maine were born to mothers who were enrolled in WIC during pregnancy? 2) What percentage of eligible women and children actually enroll in WIC? 3) Why is there a large drop in enrollment when infants go off formula? 4) What are the risk factors for discontinuing WIC participation (at all ages)? What are the protective factors for remaining in the program? 5) Are babies born to WIC mothers more/less likely to be low birth weight and/or premature than are babies in the general population? 6) Does the timing of enrollment in WIC during pregnancy (e.g. first trimester versus second trimester) affect birth outcomes such as birth weight or prematurity? 7) What are the risk and protective factors for ever-breastfeeding among women enrolled in WIC? 8) Is childhood obesity more/less common among current WIC child participants than among the general population? //2006//

Another way that we will address Indicator #9A concerns child abuse. In January 2003, the Acting Commissioner of the Department of Health and Human Services (DHHS) initiated an effort to unite the wide array of people, organizations, and communities involved in the prevention of child abuse and to highlight its importance as a public health issue. Despite three decades of legislatively mandated child protection services in Maine and across the country, the number of children reported and confirmed as victims of child abuse and neglect remains alarmingly high. In 2000, DHS confirmed a total of 4,279 Maine children as victims of abuse and neglect. In addition, an increasing number of reports received by DHHS warranted Child Protective Services. The Acting Commissioner is exerting his leadership position to inspire the citizens of Maine to make child abuse prevention a top priority and to create a culture in our state that raises the societal value of parenting to a much higher level.

/2006/ In the summer of 2004, the new DHHS Commissioner appointed the MCH Medical Director, Dr. Aronson, to the Senior Staff of the Governor's Children's Cabinet. This appointment has enabled Title V to continue to champion child abuse prevention as a high priority issue that not only requires a public health approach but also draws on the efforts of all of the Departments that make up the Children's Cabinet: DHHS, Education, Public Safety, Labor, and Corrections. In addition, Dr. Aronson's participation as a Board member of Maine Children's Trust has also provided another vehicle for keeping this issue up front as requiring a public health approach. The connection between the Children's Trust and the Early Childhood Task Force of the Children's Cabinet has strengthened as a result. In addition, the DHHS Commissioner, at a statewide home visiting conference in February 2005, supported the universal strategy for home visitation which Maine currently has in place. At the Children's Trust Annual Awards Celebration in May 2005, Dr. Aronson recived the State Agency Partner Award, another indication of Title V leadership on this issue. //2006//

A clear role for Title V is to assure that our expertise in developing humane and effective systems is interwoven with accurate information and data analysis. This helps to define the issue and monitor the extent to which changes in systems improve the health and safety of children and families. To better address Health Systems Capacity Indicator #9A, we are challenged to link databases that exist within the Bureau of Health and beyond. For child abuse, this means connecting hospital discharge, birth, and death records; Medical Examiner and police files; and DHHS databases. This effort will require the kind of inter-disciplinary collaboration and sensitivity to families and cultures that are at the heart of systems change. ***/2006/ Erika Lichter joining us in June 2005 as our doctoral MCH epidemiologist will enable us to move forward in this effort, as she has a special interest in child-related violence, including abuse. //2006//***

Measuring Maine's progress on the Health Systems Capacity Indicators will grow with our newly established Epidemiology Team (Epi Team). The Epi Team consists of the two MCH epidemiologists, three health promotion and chronic disease prevention epidemiologists, and the epidemiologist for the Behavioral and Risk Factor Surveillance System. Instead of narrowly assigning staff to projects, the Epi Team reviews all project priorities and assigns responsibility to the epidemiologist with the best mix of skills and knowledge related to the project. The MCH Medical Director provides guidance and

oversight to the Epi Team. The Epi Team will pay special attention to making sure that families and communities are involved in its efforts from start to finish, including populations that experience health disparities and inequalities.

The Health Systems Capacity Indicators also helped guide us in the 2005 Title V Strengths and Needs Assessment. We involved families and communities in the assessment; moved from a needs only assessment to also include strengths; measure systems with respect to their capacity to be family-centered, culturally competent, and focus on resiliency; take indicators previously expressed as morbidity, mortality, and risk and frame them in a positive light as well; incorporate mental and spiritual health and social capital; use non-jargon language that avoids pejorative terms such as "targeted"; measure the extent to which children feel honored and respected; and more humanely report on the variables of age, education, gender, income, race, ethnicity, culture, and geography that may show disparities.

Maine is uniquely poised to address the Health System Capacity Indicators. We have a long history of investing in services and systems for children and families. In 2003, Maine led the nation in health care reform by enacting a plan that aims to assure universal access to health insurance coverage for all citizens by 2009. Our Governor has initiated the restructure of state government so that it is more integrated in how it supports children and families. As previously mentioned, the Bureau of Health is in the process of developing an integrated public health information system that will eventually support more detailed analysis of MCH related data.
And finally, we must always keep in mind that behind every statistic is a human being -- someone who has personal, professional, and spiritual aspirations just like all of us. Each has friends and family, hobbies, dreams, eccentricities, all the things that make us wonderfully exasperatingly human. And, as Rev. Martin Luther King, Jr., said almost 50 years ago, "Our nettlesome task is to discover how to organize our strength into compelling power". /2004//

In preparing for the 2005 Strengths and Needs Assessment, which establishes new state priorities, the Maine Title V Program articulated a unique direction for the assessment. We viewed the assessment as an ideal opportunity to strengthen our Title V leadership by incorporating four key principles into the methodology for the assessment. These principles are the following:

1. Strengths, not just needs: We believe that our work to improve the health of the state's children and families should be rooted in addressing strengths as well as needs. We understand that children, families, communities, and systems are more likely to change for the better when the context for such actions includes their strengths, assets, and resiliency. Why do some families do better than others in the face of similar circumstances? How can we collect information so that it will enable us to track the answers to this and other such questions? Thus, we conducted a Strengths and Needs Assessment and shall sought, from start to finish, to identify and measure positive factors.

2. Quality, not just quantity: We aim to foster conditions that will enable children to thrive in environments that honor and respect them and that affirm their dignity. To achieve this aim, we are challenged to measure the health of the MCH population in ways that illuminate the quality of their lives and of the policies and systems that affect them. The quantitative measures with which we are most familiar and comfortable -- such as infant mortality, low birth weight, and youth suicide rates -- continue to be important. However, our Strengths and Needs Assessment should also focus on qualitative indicators at all levels. The questions that form the foundation for our assessment should stretch and flow well beyond the boundaries of numbers. To what extent are Maine's children "thriving"? To what extent are our MCH services, organizations, and systems culturally and linguistically competent? To what extent are they family-centered?

3. Inclusion of Stakeholders: One reason that Title V is a such a precious resource is that it requires us to not only assure decent services for the whole MCH population but also to establish the foundation needed to sustain such services from one generation to the next. The Strengths and Needs Assessment is a central component of this foundation and its strength rides on our commitment to involve all stakeholders in building it. Thus, family and community involvement from

start to finish was central to every last detail. And before we even started to design our assessment, our initial task was to ask again and again: Who should be at the table? Whom have we forgotten? And how do we ensure that everyone feels welcomed and that his or her voice matters in this process?

4. Cultural and Linguistic Competence: Healthy People 2010 has established a Year 2010 public health objective of 100 % access to health care and zero disparities in health status for all citizens. The attainment of such an ambitious and significant public health objective depends on the capacity of all of our health and human systems, including education and childcare and mental health, to deliver culturally and linguistically competent care. The recognition that cultural and linguistic issues affect all aspects of public health practice heighten the importance of striving to incorporate cultural competence into our Maine MCH Strengths and Needs Assessment.

In May 2004, we held a one-day workshop on cultural and linguistic competence for 20 program managers from the Bureau of Health. Two consultants from the National Center for Cultural Competence joined with a panel of Maine family and community representatives to guide the process. The purposes of the workshop were to start a process that would enable us to incorporate cultural competence into all aspects of the Strengths and Needs Assessment. This would include an organizational self-assessment of cultural competence within the Title V Agency itself; increased awareness of the dynamics inherent when cultures and languages interact; and the design of the assessment methodology so that it would give us information related to culturally competent practices at the community and state level. By infusing cultural competence into the assessment, we aim to enrich and enhance the recognition throughout Maine that cultural and linguistic competence is a high priority and a foundation for healthy and safe children and families, and the systems and policies to support them.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

/2004/ Maine is unique for a number of reasons. Geographically, Maine's land area is the size of the other 5 New England states combined. It is divided into 16 counties and has 3 large cities, Portland, Lewiston-Auburn and Bangor. Maine has a population of 1.2 million people, 2/3 of whom live in the southern third of the state. (See Section III A for more detail.) The state has a long history of local civic engagement. It has an independent, can-do spirit that fosters cooperation regardless of political beliefs. Towns continue to be the core of Maine's governmental structure in which roughly 400 of the 450 towns and cities maintain the direct democracy, town meeting format of government. County government, on the other hand, is weak.

Maine's state bureaucracy remained relatively small and underdeveloped until the 1970's and 1980's, when many federal responsibilities were transferred to the states, including Title V. In a widely published 1983 report to the National Governors' Association (America's Children: Powerless and in Need of Friends), Maine's Department of Human Services provided a compelling argument for why the unmet needs of our nation's children require governmental and societal support. Maine's public health system, including MCH, was built upon this structure. Most public health functions are concentrated at the state level. While the two largest cities (Portland and Bangor) have local public health departments, the state does not have any county health departments. The Bureau of Health's Public Health Nurses, public health educators, health engineers, and restaurant inspectors provide the local public health presence. The State's capacity to perform many categorical public health functions is extended through contracts with private health care providers and community-based organizations.

/2006/ In the past six years several proposals have been made to address the lack of a more locally based public health presence. Maine received a Robert Wood Johnson, Turning Points Grant, which provided a vehicle for convening the public health related community to design plans for a Regional Public Health System in Maine. Legislation for such a structure was submitted in the first year of the 121st Legislative Session. At the same time the Governor's Office put forth legislation for the Dirigo Health Plan which addressed many of the issues in the Turning Points legislation. It was agreed to hold the Turning Points legislation until the Dirigo Health Plan was implemented and its implementation could be evaluated. The Governor's Office of Health, Policy, and Finance is leading the discussion regarding Regional Public Health Infrastructure. A decision is pending on the number of regions there will be within the state. //2006//

/2004/ Looking at the conceptual framework for the services of the Title V MCHBG, Maine's resources have fallen more heavily within the Direct Services area resulting from the state's local limited resources. However, over the past nine years, under the direction of Valerie Ricker, the Title V Program has shifted its priorities from primarily funding direct MCH services to also supporting efforts and projects that promote the development of family-centered MCH systems of services and care. The emphasis has shifted from relying on the MCH Block Grant for direct service provision to using it as an innovative planning and system building tool and to implement a view of child and family health within an interlinked ecological context. The interlinked ecological context refers to the role of environments -- at the family, neighborhood, community, state, and societal levels - in promoting better health and developmental outcomes. Thus, we have adjusted the balance of human and financial resources so that they are more in alignment with Title V's role in strengthening public health capacity and infrastructure at the local and regional level. The beauty of Title V is that it gives states the flexibility to adjust their role and function to that of placing a greater focus on core public health functions and quality assurance in relation to direct services provided at the local and regional level. Maine's Title V activities, by level of the pyramid for the MCH population, are summarized in the attached table. //2004//

B. STATE PRIORITIES

The Maine MCH Title V Program uses the 1988 Institute of Medicine definition of public health as "the process of assuring the conditions in which people can be healthy". The Maine Title V Program is rooted in the vision that families and communities, and our state as a whole thrive when children of all ages enjoy optimal health; feel physically and emotionally safe; are treated with dignity and respect; enter adulthood equipped with intense curiosity about the world, a deep desire to learn, a resilient spirit, and a healthy balance of cognitive and emotional skills; and have a sense of purpose, hope, and power about their lives, so that they can become compassionate and productive individuals.

The priorities selected for the next five years were developed based upon the in-depth analysis of the health of the MCH population through quantitative and qualitative data. While the priorities are listed as 1-10, this does not mean that number 1 has a higher rating than 10. From the Title V Program perspective, they are all of equal value. The priorities are very broad in nature. This was intentional in that all people who work with and care about the MCH population have a stake in working together in a synergistic way on achieving these priorities. Also, while the MCH Block Grant is the fuel that drives our leadership, the MCH Title V Program is much more than the Block Grant itself. In addition, we decided to word the priorities in positive phrases such as "improve", "increase", and "foster conditions" to reflect our commitment to measuring strengths as well as needs.

Although the priorities are broad, they are more specific than the priorities selected in 2000. The 2000-2005 priorities were more focused upon how we would achieve our work and a couple of specific health priorities. The 2005-2010 priorities identify specific areas of health, but at the same time are broad enough to ensure inclusion of the whole MCH population in focused activities and in all aspects of a priority. We felt that too much specificity would jeopardize the obvious importance of many issues not making the list, and give the false impression that we favor addressing only certain segments and age groups of the MCH population.

The 10 priorities and the rationales are as follows:

1. Improve Birth Outcomes

While Maine does better on many birth outcomes than does the nation as a whole, the state has not yet met many birth-related Healthy People 2010 and Healthy Maine 2010 objectives, and the proportion of premature births has increased significantly during the past decade. We view the following objectives as examples of what we intend to address for achieving this priority: reductions of prematurity, low birth weight, and perinatal morbidity and mortality, including perinatal substance abuse; reductions in teen pregnancy; and increases in social support for pregnant women and early prenatal enrollment for WIC and home visiting.

2. Improve the safety of the MCH population, including the reduction of intentional and unintentional injuries

Unintentional injuries are the leading cause of death for 1-19 year olds and the second leading cause of death for women ages 20-44 in Maine. Unintentional injuries also are one of the most common principal diagnoses of hospitalizations among these groups. Suicide is the second-leading cause of death among 15-24 year olds and the fourth leading cause of death among women ages 20-44 in the state. The definition of safety encompasses physical, psychological, and emotional safety and includes a public health approach to the prevention of violence. Injuries range from those sustained in automobile crashes or falling off the equipment at the playground to those intentionally inflicted by another or by oneself. The ability of our families and children to feel safe at all times is paramount and this can only be accomplished through a variety of mechanisms to include a wide variety of violence prevention, including domestic, physical, sexual, child abuse and neglect, bullying, suicide and poisoning prevention initiatives.

3. Improve the respiratory health of the MCH population

Almost 1 in 11 kindergartners in Maine have asthma, as do nearly 1 in 8 women ages 18 and older. Only 37% of the kindergartners with asthma have a written management plan. Asthma also is one of the most common principal diagnoses in hospitalizations of 1-9 year olds in the state. Smoking, and second-hand smoke affect the respiratory health of a large proportion of the MCH population in Maine. Research has shown that children are able to learn and adults are more productive if living and working in healthy environments. We feel this can only occur if we support efforts that include the reduction of environmental [indoor and outdoor] hazards, such as first and second hand smoke, mold, and smog; and the reduction of the incidence and burden of asthma.

4. Increase the proportion of the MCH population who are at a healthy weight and physically active

Large segments of the MCH population in Maine are overweight or at risk for overweight. The problem begins in early childhood (where 16% of 2-4 year olds enrolled in WIC are overweight and another 17% are at-risk-for-overweight) and continues through adulthood (where nearly half of women aged 18 and older are at risk for health problems related to being overweight). In addition, significant proportions of the Maine MCH populations are not physically active. For all our children, including CSHN and people with disabilities, to thrive and be healthy and happy they need to engage in physical activity and have access to information on nutrition as well as nutritious food. This is an area that a wide range of partners in public health can contribute to both individually and collectively.

5. Improve the mental health system of services and supports for the MCH population

Mental disorders affect a large proportion of the MCH population in Maine. For example, these disorders are one of the most common principal diagnoses for hospitalizations among Maine children ages 5-19 and Maine women 20-44 years old. One study estimated that 1 in 6 rural Maine children has a behavioral health problem. One in four high school students reported feeling so sad or hopeless for 2 or more weeks in a row that they stopped doing some usual activities. More than half of all new mothers in the state reported at least some degree of postpartum depression. Mental health and the lack of available services, as well as family stress, were identified as key needs by dialogue group participants. When we use the word "mental health", we are including all aspects of social, emotional, and behavioral health as important components of the mental health system. It is time to formalize the reality that mental health is integral to MCH. Research indicates that a large percentage of children with the most significant behavioral and emotional symptoms never receive any services at all. A lack of licensed clinicians and psychiatrists results in primary care physicians having to provide services. Through enhanced partnerships with our colleagues in mental health at the state and local level, and through such initiatives as the Behavioral Women's Health Grant, Early Childhood Comprehensive Systems Grant, and the Harvard Prevention Resource Center we will aim to integrate mental health into primary health for the MCH population.

6. Foster conditions to improve oral health services and supports for the MCH population

Our state's large geography coupled with a shortage of dentists has resulted in large numbers of the MCH population lacking adequate dental care. Dialogue group participants identified the lack of dental care resulting primarily from a demand that exceeds the number of providers as a key issue in the state. Poor oral health can and does impact the overall health of individuals. We will work to support efforts that enable increased access for our children and families to integrate oral health into primary health care and schools for the MCH population.

7. Foster the conditions that enable the CSHN Program to move from a direct care focus to a community-based system of care that enables the whole CSHN population to achieve optimal health

CSHN must have the opportunity to achieve their optimal potential in all areas of health and development. We can be much more successful in this effort through systemic change that uses a public health approach to serving this population. Our challenge is to transform our CSHN Program so that it aims to put into practice systems of care that support family-centered and culturally and

linguistically competent service in all communities for all children with special health needs.

8. Foster conditions to expand the medical home model to a comprehensive health home system for the entire MCH population

We know that the quality of life for families improves when obstacles to needed services and resources are removed. Our care coordination approach, as currently incorporated into the medical home model for children with special health needs, is an example of what we should make available to the whole MCH population. A Health Home includes but goes beyond the Medical Home. It is rooted in our vision of health and includes the physical, mental, emotional, and spiritual realms of the person and family. It represents a standard that we will aim to make available for all children in our state.

9. Improve cultural and linguistic competence within the system of services for the MCH population

It is essential that we honor and respect the culture and language of all children, families, and communities in Maine; and that we incorporate cultural and linguistic competence into every aspect of MCH in Maine. Such an approach is necessary in aiming to move toward the Healthy People 2010 objective of 100% access to health care and zero disparities in health status for all citizens. It depends on the capacity of all of our health and human systems, including education, childcare and mental health, to deliver culturally and linguistically competent care and services. Dialogue group participants felt that Maine is not yet doing a very good job of supporting issues of diversity and culture and that this is an important issue to address. We will begin this process by first conducting a self-assessment of cultural and linguistic competence within the Title V Agency and MCH supported agencies, and identify organizational goals and actions for improvement. We will use these self-assessments to work with our partners on areas of improvement.

10. Integrate existing services and supports for adolescents and young adults into a comprehensive system that draws upon their own strengths and needs

To foster life-long healthy habits and health, youth need services, supports and opportunities. Health care services, including oral and mental health care, must be provided where young people are and be sensitive to the unique concerns and barriers that they face. Supportive environments and adult allies can help them develop competencies and connections that help prevent unhealthy risk behaviors and promote overall health. Actively partnering with youth in meaningful ways fosters conditions for successful endeavors and continued participation.

The Maine Title V Program has selected 7 performance measures related to the above priorities. We anticipate over the next two to three years we will develop one to three additional measures related to the 10 priorities. Areas under consideration for developing future state performance measures include: tobacco use in pregnancy, mental health, cultural and linguistic competence, early childhood, child abuse, and something state specific related to asthma. The performance measures selected for Maine are:

1. The percentage of births in women less than 24 years of age that are unintended
2. The percentage of 0-11 month old children enrolled in WIC who were ever breastfed
3. The motor vehicle death rate per 100,000 among children 15 to 21 years of age
4. The percentage of high school students (grades 9-12) who are overweight
5. The percentage of high school students (grades 9-12) who feel like they matter to people in their community
6. The percentage of elementary schools that have developed and implemented a comprehensive approach to the prevention of bullying in collaboration with the Maine Injury Prevention Program
7. The rate per 1,000 of emergency department visits for asthma among women ages 15-44

In preparing our report for FY06 we based our discussions on the following priorities developed during the 2000 needs assessment. Those priorities are:

1) Building systems and community capacities
2) Initiating and advocating for public health policy
3) Developing and delivering humane and family-centered programs and services
4) Collaborating with others
5) Providing leadership
6) Establish a broad based Maternal and Child Health Program Advisory Committee
7) Improve nutrition and physical activity for the MCH population
8) Enhance adolescent health initiatives and programs
9) Integrate MCH activities with tobacco cessation and prevention activities.
10) Coordinate across Programs and Divisions on common issues

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	99	99	98	98	98
Annual Indicator	99.8	99.8	100.0	100.0	100.0
Numerator	13559	13534	19	23	24
Denominator	13590	13566	19	23	24
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center)

Indicators prior to 2002 are not accurate for this measure due to a misunderstanding concerning how it should be calculated. The 2002 and 2003 indicators were updated in September 2005 to meet the definitions provided in the block grant guidance.

As of July 2001, Maine screens for 9 mandatory conditions (including hemoglobinopathies) and has an optional panel of 19 metabolic disorders.

Notes - 2003

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Notes - 2004

The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center)

Indicators prior to 2002 are not accurate for this measure due to a misunderstanding concerning how it should be calculated. The 2002 and 2003 indicators were updated in September 2005 to meet the definitions provided in the block grant guidance.

As of July 2001, Maine screens for 9 mandatory conditions (including hemoglobinopathies) and has an optional panel of 19 metabolic disorders.

a. Last Year's Accomplishments

/2006/ Maine consistently screens over 99% of infants born in the state. During CY04, Maine screened 13,650 of the 13,709 births (preliminary) that occurred in the state representing 99.5 % of newborns screened. //2006//

In July 2001, Maine began offering an expanded panel of screening for 19 tests to newborns. 99.8% of Maine infants that received the mandatory screens were also screened during CY03 for the expanded panel of disorders.

/2006/ During CY03, 22 infants were identified with disorders through newborn bloodspot screening. The disorders included Partial Biotinidase Deficiency, PKU, Congenital Hypothyroidism, Galactosemia Duarte Variant, MCAD, Congenital Adrenal Hyperplasia, Homocystinuria IVA, and MCC. Two infants were identified with more rare disorders through the optional expanded screen, as well as, one with Homocystinuria which is also quite rare. All infants, except one, did not have a family history of disorders and would not have been identified early without newborn screening. All affected infants were receiving appropriate consultation and treatment within 48 hours of confirmation.

In FY04 the Newborn Screening Program Advisory Committee continued to add more family members and took steps toward being more family centered in its structure. A parent co-chairs the committee. The committee, now known as the Joint Advisory Committee (JAC), advises both the Newborn Screening and Children with Special Health Needs Programs for the identification and management of children with conditions discovered through newborn blood spot screening.

A survey was administered in the spring of 2003 to evaluate the effectiveness of parental education related to newborn bloodspot screening. When the Advisory Committee recommended Optional Expanded Screening, they intended for all mothers to receive a booklet describing the screening program and a discussion to occur with a health care

provider to determine if the mother accepted or declined the optional expanded screening. Mothers, over the age of 18, giving birth to a live infant during February 2003, received the survey. Of the 815 surveys distributed 209 responded, a 26% response rate. Respondents reported limited knowledge of newborn screening.
- 16.8% had never heard of newborn bloodspot screening.
- 38% were unsure if their baby had been screened for the mandated disorders
- 72.9% were unsure if their babies had received the optional screening.
- Less than half the mothers remembered receiving a brochure.

/2006/ Survey results were shared with the JAC and distributed to Perinatal Nurse Managers. The JAC recommended distribution of the program booklet and encouraged nurses to provide the booklet and have a dialogue with families regarding newborn screening. Perinatal Nurse Managers agreed to share this information with their nurses and incorporate more education in the discharge process. The program is currently at full staff allowing more work on education and quality assurance to occur. //

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluate effectiveness of the screening system				X
2. Develop and distribute quarterly newsletter on Genetics and Newborn Screening			X	
3. Develop program resources				X
4. Develop a plan for education of providers and the public				X
5. Continue work with CSHN re: transition of clients between programs		X		X
6. Finalize and disseminate program manual to health care providers				X
7.				
8.				
9.				
10.				

b. Current Activities

A technical review team from the National Newborn Screening and Genetics Resource Center visited Maine in April 2004. The Team reviewed all aspects of the Program and issued a comprehensive report in September 2004 (Copy included in Appendix). Comments included strengths and opportunities with specific resources identified for future activities. Some areas of focus this year included strengthening communication and feedback to hospitals and providers on performance and program initiatives, review of current screening panels, and possible expansion to include Cystic Fibrosis. The first quarterly Genetics and Newborn Blood Spot Screening designed and distributed its first quarterly newsletter in February 2004. Approximately 1,000 copies of the newsletter were distributed to perinatal care providers (obstetricians, nurse midwives, hospital nurse managers, pediatricians, and the Advisory Committee. The Program received much feedback along with requests for additional copies and suggestions for future topics.

A program manual is under administrative review and will be distributed to Obstetric and Pediatric health care providers and birthing hospitals. The manual consists of information on the Newborn Screening Program, the conditions including screening panels, program and provider responsibilities, as well as, a list of resources

c. Plan for the Coming Year

During FY06 the Joint Advisory Committee (JAC) for Newborn Screening (NBS) and Children with Special Health Needs (CSHN) will be considering recommendations relating to the expanded screening tests now offered as an optional panel. The group will carefully review the report of the American College of Medical Genetics to HRSA, "Newborn Screening: Toward a Uniform Screening Panel and System", released for public comment in March 2005. Accompanying materials and clinical expertise of specialists in Maine will be discussed as Maine makes decisions on its panel of newborn screening tests. Included in these discussions will be the addition of cystic fibrosis to the screening panel. The JAC will also be assessing the capacity of the clinical and programmatic components of the screening system and considering statewide system improvements. Ana Cairns, MD is invited to the JAC meetings to discuss issues of mutual concern and interest. The Genetics Program will attend the next statewide Cystic Fibrosis Center meeting in the fall 2005 to explore the impact of newborn screening on the system of care for identified infants.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14	15		62.8	62.8
Annual Indicator	15	14	62.8	62.8	62.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62.8	62.8	75	75	75

Notes - 2002

Percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

The 2002 indicator of 62.8 % is based on the State estimates from SLAITS. We project an objective of 75 % for 2007 following the next administration of SLAITS when survey data becomes available. However, objectives for 2003-2006 are based on the 2002 indicator because we have no mechanism to assess it. The indicators for 1998 - 2001 are NOT percentages. They reflect the average score (on a 0 to 18 point scale) of a family participation questionnaire. Under Toni Wall's CSHN leadership, the method for determining the score

changed in 2000 so that parents themselves answered the questionnaire. This represents a more accurate measure of parental involvement in the CSHN Program.

Notes - 2003

The indicator for 2002 of 62.8 % is based on the first SLAITS Survey carried out in 2001. It is comparable to the national indicator of 57.5%. An objective of 75% is projected for 2007 when survey data becomes available from the second administration of SLAITS.

The indicators for 1998 to 2001 are NOT percentages. They reflect the average score (on a 0 to 18 point scale) of a family participation questionnaire. The method for determining the score changed in 2000 so that parents themselves answered the questionnaire. This represents a more accurate measure of parental involvement in the CSHN Program.

Notes - 2004

The 2004 indicator 62.8 % is the value for Maine from the the first National CSHCN Survey carried out in 2001. It is comparable to the national indicator of 57.5%. An objective of 75% is projected for 2007 when data become available from the second administration of the survey.

The indicators for 1998 to 2001 are NOT percentages. They reflect the average score (on a 0 to 18 point scale) of a family participation questionnaire. The method for determining the score changed in 2000 so that parents themselves answered the questionnaire. This represents a more accurate measure of parental involvement in the CSHN Program.

a. Last Year's Accomplishments

The 2001 National Survey of Children with Special Health Care Needs found that 90.9% of families surveyed felt the doctor usually or always made the family feel like a partner in decisions. However, families were only 65.6% satisfied with the services they received. In an effort to substantiate the above findings our Healthy and Ready to Work (HRTW) Project, MaineWorks for Youth, conducted a survey of 150 families of children and youth with special health needs. Our survey found that Maine families were generally satisfied with the degree of services they received in the areas of compassionate care (88.6%), comprehensive (80%), and coordinated care (83.3%). It was not surprising to find that families are less than satisfied (58%) with access and availability of community resources.

The results of a MaineWorks for Youth survey prompted the Children with Special Health Needs (CSHN) Program to make minor adjustments to the Health Care Notebook. The Health Care Notebook was printed and 2,200 copies were distributed to families, physicians, early intervention agencies and clinics throughout Maine. The Maine Health Care Notebook developed by members of the CSHN Family Advisory Council (FAC) and the Center for Community Inclusion and Disability Studies, is a resource for parents. The Health Care Notebook is also being used with AAP practices involved in the Medical Home Learning Collaborative.

Building on the energy from the Champions for Progress meeting Kathy Phillips and the CSHN Program spent the last year redefining roles and responsibilities of the FAC. The FAC continues to have statewide representation of families and key State Agencies with a focus on Children and Youth with Special Health Needs (CYSHN). The FAC addressed the issue of membership and conducted a statewide effort to encourage new families to join. The FAC recognizes that one of the largest hindrances to joining may be schedules. The FAC feels they can be most effective hosting a yearly conference to educate and build awareness among families. The FAC also launched it's website at http://www.maine.gov/dhhs/boh/cshn/fac.htm

Traumatic Brain Injury (TBI) is housed in the CSHN Program. The Acquired Brain Injury Advisory Council (ABIAC) was established and consists of individuals with TBI, families, providers, key state agencies, the disability community and others with a vested interest in this area. The ABIAC established a vision and mission, a regular schedule of meetings, operational

by-laws and a 2-year strategic plan. Subcommittees will address membership, finance/sustainability, by-law revision, and legislation. Members of the ABIAC met with the Commissioner of the Department of Health and Human Services to update him on TBI issues and offer assistance during the merger of the Departments of Health and Human Services and Behavioral and Development Services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to recognize families as partners through the Family Advisory Council		X	X	X
2. Continue to have parents complete the Form 13 and address concerns brought forth.		X	X	X
3. Continue contracts with parent consultants as appropriate		X	X	X
4. Active participation on Lead Advisory, Newborn Hearing Advisory , Joint Advisory Committee of the Newborn Screening &CSHNP,ECCS Grant		X	X	X
5. Enhance FAC activities by exploring & integrating with other family groups similar to those involved with planning of Special Family Weekend		X	X	X
6. Continue to involve the Family Advisory Council in the development of the Champions for Progress Grant		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

The Family Advisory Council to the Children with Special Health Needs Program completed Form 13 at their June 17, 2005 meeting. The CSHN Program does extremely well involving family members on the advisory committee and offers stipends and reimbursement for mileage. The program also assists other parent groups such as the Annual Special Family Weekend held each year in Castine, Maine. Title V routinely involves family members in the review process of the MCH Block Grant and they are invited to attend the annual review. The FAC would like to see the CSHN Program do more in the areas of family member contribution to in-service training and family members as paid staff. The FAC also feels that family members from diverse cultures are involved in many aspects of Title V.

The HRTW, MaineWorks for Youth Project is in it's final grant year and plans are underway to complete the "Roadmap to Success: What We Have Learned Along the Way," a resource to help youth who have a special health need or disability, identify and address challenges they may face as they move into adulthood.

The ABIAC, the Brain Injury Association of Maine and the CSHN Program are completing "The Silent Epidemic: Traumatic Brain Injury Services, Experiences and Expectations in Maine," a compilation of the needs and resource assessment conducted during 2003 -- 2004.

c. Plan for the Coming Year

During FY06 the FAC will hold it's 5th Parent Conference in Bangor, Maine.

The ABIAC, Brain Injury Association of Maine, and the CSHN Program will complete the Traumatic Brain Injury State Action Plan.

Discussions will be held to explore sustainability of the Family-to-Family Resource Centers. Funding ends June 06 and there is a vested interest to continue those centers.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	70	75		60	60
Annual Indicator	68.0	79.9	60	60	60
Numerator	36884	43319			
Denominator	54223	54223			
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	65	65	65

Notes - 2002

The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

The 2002 indicator of 60 % is based on the State estimate from SLAITS. We project an objective of 72 % for 2007 following the next administration of SLAITS when survey data becomes available. However, objectives for 2003-2006 remains the same as the 2002 indicator because we have no other population wide mechanism to assess it.
The percentages for 1998 to 2001 refer to the original PM #3. For 1998, the numnerator and denominator were based on estimates from the 1992 National Health Information Survey (NHIS), adjusted for Maine. From 1999-2001, the CSHN Program used an 18% prevalence rate based on Newacheck's work.

Notes - 2003

The 2002 indicator of 60% is the measure for Maine from the SLAITS Survey. This is higher than the national measure of 52.6 %. An objective of 72% is projected for 2007 when the survey data from the next administration of SLAITS becomes available.

The percentages for 1998 to 2001 refer to the original NPM # 3. For 1998 the numerator and denominator were based on estimates from the 1992 Nathional Health Information Survey (NHIS), adjusted for Maine. From 1999-2001, the CSHN Program used an 18% prevalence

rate based on the work of Paul Newacheck.

Notes - 2004

The 2004 indicator of 60% is the value for Maine from the first National CSHCN Survey in 2001. This is higher than the national measure of 52.6 %. An objective of 72% is projected for 2007 when data from the next administration of the survey become available.

The percentages for 1998 to 2001 refer to the original NPM # 3. For 1998 the numerator and denominator were based on estimates from the 1992 Nathional Health Information Survey (NHIS), adjusted for Maine. From 1999-2001, the CSHN Program used an 18% prevalence rate based on the work of Paul Newacheck.

a. Last Year's Accomplishments

The Maine CSHN Program made great strides in moving forward with the medical home initiative during FY04. The Champions for Progress Grant, awarded by Utah State University, Early Intervention Research Institute, allowed the CSHN Program to build a stronger partnership with our colleagues at the Maine Chapter of AAP. Through shared visions we increased out efforts to build community-based systems of care for children with special health needs and their families. Activities of this grant include a survey of Maine Chapter of AAP members to learn more about the key components of care physicians feel are important for children with special health needs using the Medical Home Assessment Survey for Physicians (2000), Los Angeles Medical Home Project for Children with Special Health Care Needs. The survey is being conducted using Survey Monkey. To increase awareness of community based resources and enhance communications between Chapter members, the CSHN Program, in collaboration with the Maine Support Network, supported the creation of the Chapter's new website through a Champion's for Progress Grant. The website was unveiled to members at their annual meeting in May 2005 and will be launched by the end of June 2005.

A 2003 Bureau of Medical Services, MaineCare survey on the Coordination of Care for Children with Special Health Needs reported findings from a random telephone survey of 1,251 parents/guardians of children with special health needs who receive MaineCare benefits through adoption assistance, foster care services, Katie Beckett, SSI, and Title V (CSHN Program). The survey instrument was adapted from the Family Survey in "Shared Responsibilities: Tools for Improving Quality Care for Children with Special Health Care Needs," New England Serve. Key findings included:
- The Title V Program had the highest satisfaction and fewest unmet needs of any eligibility category.
- 99% of children with special health needs receiving MaineCare have a primary care provider, indicating they have a medical home where they receive primary care services.
- Children who receive MaineCare benefits through the Katie Becket option and SSI report a greater number of unmet needs, a lower satisfaction rating of services, and the highest utilization of services.

The CSHN Program conducted a survey of 150 families enrolled in the CSHN Program. The survey instrument was adapted from the Family Satisfaction Survey "Every Child Deserves a Medical Home," American Academy of Pediatrics. Key findings included:

- 95% of the families indicated their child's PCP responds quickly during times of emergent care.
- 88% of families are satisfied with the environment of the office and feel supported by staff.
- Only 47% of families felt the PCP provided them with information to access community-based services.

These and pediatrician results will be used to develop a state plan to increase the awareness and value of a medical home for children with special health needs in Maine

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation in the Medical Home Learning Collaborative	X	X	X	X
2. Enhanced collaboration and partnership with the Maine Chapter of the AAP			X	X
3. Launched the Maine Chapter of the AAP website		X		X
4. Participation in the New England Rural Pediatrics Annual Meeting				X
5. Participation in the Partners in Chronic Care Model		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHN Program is currently participating in the National Initiative for Children's Healthcare Quality's (NICHQ) Medical Home Learning Collaborative. The purpose of this learning collaborative is to improve care for children with special health needs by implementing and disseminating the medical home concept. Currently Dr. Patricia Nobel of the Nobel Clinic is participating. The Nobel Clinic is a small rural pediatric office in Lincoln, Maine serving approximately 2000 children, 75% who receive Medicaid. Dr. Nobel identified several areas of improvement; identify, develop and use a registry of children and youth with special health needs (CYSHN), develop care plans for those identified as CYSHN, develop a way to identify and meet family concerns, and improve access to community-based resources. To date, the Nobel Clinic is using the CAHMI screener to identify children with special health needs. Dr. Nobel will use the Family Satisfaction Survey "Every Child Deserves a Medical Home," American Academy of Pediatrics," to assess satisfaction among her patients.

Another medical home initiative, Partners in Chronic Care (PCC) was established with a federal grant from the Maternal Child Health Bureau through the Hood Center at Dartmouth Medical School in New Hampshire to develop and implement a model of care coordination for children with complex chronic conditions based in the primary care practice. The Hood Center chose Maine to pilot the program in years 3 and 4 of the grant. As of April 2005, four primary care practices were enrolled and include; Neurumbega Pediatrics, Bangor; Kennebec Pediatrics, Augusta; Prime Care Physicians, Kennebunk, and Bridgton Pediatrics, Bridgton. The PCC concept is a family-centered process that involves the family, Pediatrician, PCC Coordinator, insurance case manager and others in solving a wide range of problems encountered by children with complex health conditions.

c. Plan for the Coming Year

Our ability to improve care for children with special health needs at the community level is enhanced by our relationship with the Maine Chapter of AAP. The collaborative relationship will continue to grow and improve as we move forward with our initiatives to spread the medical home concept of care. We intend to broaden the number of primary care practices currently participating in both the medical home learning collaborative and partners in chronic care initiative. Using existing practices as mentors we will add an additional 5 -- 10 practices that are geographically distributed across the state. The CSHN Program and the Hood Center at

Dartmouth Medical Center will continue to provide support and technical assistance to assist practices as they move forward with change.

In addition, the CSHN Program will present survey data from the Medical Home Assessment Survey for Physicians to the Maine Chapter of AAP Executive Board. This will provide the Chapter with the necessary information to identify physician concerns and to develop a plan to improve care for children with special health needs in the medical home.

Finally, using the model of collaboration that we built with the Maine Chapter of AAP we will develop a similar relationship with the Maine Chapter of Family Practice Physicians.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85		67.3	67.3
Annual Indicator	82.0	82.0	67.3	67.3	67.3
Numerator	742	720			
Denominator	905	878			
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	67.3	67.3	67.3	67.3	67.3

Notes - 2002

The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

The 2002 indicator of 67.3 % is based on the State estimates from SLAITS. We project an objective of 75 % for 2007 following the next administration of SLAITS when survey data becomes available. However, objectives for 2003-2006 remain the same as the 2002 indicator because we have no other population wide mechanism to assess it.

The indicators for the years prior to 2002 refer to the percentage of children directly served by the CSHN Program who had adequate insurance. Please disregard 1998 data, source unclear.

Notes - 2003

The 2002 indicator of 67.3% is from the SLAITS Survey. This is higher than the national indicator of 59.6%. An objective of 75% is projected for 2007 when the survey data from the next administration of SLAITS is available.

The indicator for the years prior to 2002 refer to the percentage of children directly served by the CSHN Program who had adequate insurance.

Notes - 2004

The 2004 indicator of 67.3% is the value for Maine from the first National CSHCN Survey in 2001. This is higher than the national measure of 59.6 %.

An objective of 75% is projected for 2007 when data from the next administration of the survey become available.

a. Last Year's Accomplishments

The 2001 National Survey of Children with Special Health Care Needs found that 95% of Maine children with special health needs were insured at the time of the survey. Almost 1 in 11 (8.8%) children had been without insurance at some point during the prior year. Of the currently insured children, almost three-quarters (72.8%) of families reported that their child's coverage was adequate, and 27.2% reported coverage was not adequate. These figures are consistent with 75% of families reporting that costs not covered by insurance were always (41.0%) or usually (35.0%) reasonable while 24.0% reported that costs not covered by insurance were never or only sometimes reasonable.

To address the complex issue of insurance coverage the Children with Special Health Needs (CSHN) Program partnered with the Hood Center at Dartmouth-Hitchcock Medical Center in New Hampshire, the Maine Chapter of the American Academy of Pediatrics (AAP), MaineCare, Anthem Blue Cross/Blue Shield, Family Voices, and families to implement Partners in Chronic Care (PCC) in Maine. PCC is a care coordination model based in the Primary Care Practice Program of the Hood Center for Children and Families and supported by the Maternal and Child Health Bureau, Health Resources Services Administration. PCC promotes collaboration between key providers that include primary care, school, insurers, family, specialty care, and the broader community-based resource providers. Through the Maine Chapter of AAP four practices are enrolled. Practices are responsible for identifying a Practice Care Coordinator, identifying potential participants, participating in a home visit to assess family's needs, concerns, and/or priorities, and implement and monitor the care coordination plan. Anthem and MaineCare are responsible for participating in the home visit, assisting practices to identify families through specific utilization reports, and facilitating sharing of resources. Families are responsible for identifying needs, priorities and concerns, and attending team meetings. Maine is now ready to begin full implementation of the PCC model. All Practice Care Coordinators from Maine attended trainings in New Hampshire, and families selected and agreed to participate.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the Hood Center for Children and Families in Dartmouth, New Hampshire MCHB Health Insurance and Financing Initiative	X	X	X	X
2. Establish relationship with the Bureau of Medical Services, MaineCare		X	X	X
3. Established relationship with Anthem Blue Cross/Blue Shield		X		
4. Established partnership with the Maine Chapter of AAP		X	X	X
5. Identified 4 practices to participate in the PCC model		X	X	X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The majority of activities are centered on identifying practices, establishing a Practice Care Coordinator in each practice, training and identifying families to participate. We will begin seeing families by the end of June 2005. Relationships established through the PCC model are rewarding. Provider Relations at MaineCare see the benefit of this model through reduced costs for some of the more complex children. The CSHN Program was asked to report our efforts in this area to the MaineCare Medical Advisory Panel.

c. Plan for the Coming Year

Over the next five years the Maine CSHN Program will be focusing less on direct services and more on a community-based system of care where all families have access to services. The yearlong approach to building partnerships with the Maine Chapter of AAP, insurers, and other agencies has proved beneficial, as all are ready to move forward on implementing PCC. During the next year the CSHN Program and the Maine Chapter of AAP plan on expanding the PCC model to four additional practices in Maine. These practices will provide Maine a cadre of primary care physician offices who are prepared to meet the needs of families. The CSHN Program plans to explore the possibility of developing a relationship with the Maine Chapter of American Academy of Family Physicians.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				77.3	77.3
Annual Indicator			77.3	77.3	77.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77.3	77.3	79	79	79

Notes - 2002

Percent of children with special health care needs age 0 to 18 whose families report the

community-based service systems are organized so they can use them easily. (CSHCN Survey)

The indicator of 77.3 % for 2002 is based on the State estimate from SLAITS. This is a new measure; no data is available prior to 2002. We project an objective of 85 % for 2007 following the next administration of SLAITS when survey data becomes available. However, objectives for 2003-2006 remain the same as the 2002 indicator because we have no other population wide mechanism to assess it.

Notes - 2003

The indicator of 77.3% for 2002 is from the SLAITS Survey. This is comparable to the 74.3 % for the nation as a whole. An objective of 85% is projected for 2007 when the data from the next administration of SLAITS will be available. This was a new measure in 2002 and no data is available prior to 2002.

Notes - 2004

The 2004 indicator of 77.3% is the value for Maine from the first National CSHCN Survey in 2001.This is comparable to the 74.3 % for the nation as a whole. An objective of 85% is projected for 2007 when the data from the next administration of SLAITS will be available. This was a new measure in 2002; no data are available prior to 2002.

a. Last Year's Accomplishments

The 2001 National Survey of Children with Special Health Care Needs found that 77.3% of families felt services were usually or always organized for easy use.

The Children with Special Health Needs (CSHN) Program, through a Champions of Progress Grant, collaborated with the Maine Chapter of American Academy of Pediatrics to develop a website for the Chapter. The Chapter anticipates launching the website in summer 2005. The Champions for Progress Grant also allowed us to conduct a survey of the Chapter's members regarding key components of care physicians feel are important to children with special health needs. Of particular interest is pediatrician's knowledge of community-based resources.

The Maine Parent Federation and the CSHN Program, through Project REACH, (Responsive Advocacy for Children's Health) continue to support the regional information centers by providing training to parents. Parents receive information on state and local systems of care, communication and advocacy skills, and community resources. The goal of Project REACH is to establish family-directed, community-based health care information centers across Maine. A state-wide advisory committee and regional advisory committee was established to advise and support parent to parent activities in Maine. The CSHN Program provides reimbursement for mileage and a stipend to families who attend the parent training. The training is designed to assist parents in becoming familiar with advocating, communication skills, community and state level resources, and be a supportive parent. As of this report, 100 parents have been trained across the state.

The CSHN Program launched it's website with a downloadable version of the application. One interesting feature is direct access to the CSHN Director. To date, there have been several inquiries on applying for the program, and a family is interested in becoming a member of the Family Advisory Council. Both the Young Advocators and Educators of Maine (YEA ME) and FAC websites are linked to the CSHN site.

Collaboration continued with the Acquired Brain Injury Association, the Brain Injury Association of Maine and other key public and private agencies to enhance the development of a coordinated State system of services and supports for individuals with traumatic brain injury and their families.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHN website launched http://www.maine.gov/dhhs/boh/cshn/home.html		X	X	X
2. YEA ME website linked to the CSHN website (www.ume.maine.edu/cci/service/maineworks)		X	X	X
3. Transition Northern Cleft Lip/Palate & Southern Maine Metabolism Clinics to community-based agencies				X
4. Complete the Silent Epidemic: Traumatic Brain Injury Services, Experiences, and Expectations in Maine."				X
5. Establish a TBI Program housed in the Office of Adults with Cognitive and Physical Disabilities Services		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHN Program and the Muskie School of Public Service completed Phase I of the Environmental Public Health Tracking initiative to develop a surveillance system for the Developmental Evaluation Clinics (DEC). Phase I involved physician and staff interviews to determine current data, method of collection, and data use. Phase II will involve defining common measures, indicators and data collection protocols.

The FAC and the CSHN program are preparing for the 5th Annual Parent to Parent Conference in October 2005.

c. Plan for the Coming Year

The CSHN Program will transition the Southern Maine Cleft Lip/Palate Clinic to the appropriate community-based agency. Currently cleft lip/palate services are administered through the CSHN central office.

The CSHN Program will continue the process of transitioning from a direct service program to a comprehensive community-based system of care for children with special health needs and their families. The first steps in this process are to complete a CAST-5 assessment of the program, continue to build and strengthen partnerships, develop a strategic plan, and implement the plan at the community level.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				14.9	14.9
Annual Indicator			14.9	14.9	14.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14.9	14.9	20	20	20

Notes - 2002

The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

The indicator of 14.9 % is based on state estimates from SLAITS. This is a new measure for 2002. No prior data is available. We project an objective of 25 % for 2007 following the next administration of SLAITS when survey data becomes available. However, objectives for 2003-2006 remain the same as the 2002 indicator because we have no other population wide mechanism to assess it.

We are duly proud that Maine holds the distinction of being the only state in the nation to be able report this indicator.

Notes - 2003

The indicator of 14.9% is based the SLAITS Survey. An objective of 25% is projected for 2007 when the survey data from the next administration of SLAITS is available. This was a new measure in 2002 and there is no data available before 2002. Maine is the only state in the union with enough information to reliably report on this measure. The national indicator is 5.8%.

Notes - 2004

The indicator of 14.9% is the value for Maine from the first National CSHCN Survey in 2001. This is comparable to the national indicator of 5.8%. Maine is the only state in the county with sufficient sample size to reliably report on this measure.

An objective of 25% is projected for 2007 when the survey data from the next administration of SLAITS is available. This was a new measure in 2002; no data are available before 2002.

a. Last Year's Accomplishments

The 2001 National Survey of CSHCN found that 75.3% of doctors talked about the changing needs, as the child becomes an adult. However, research revealed that only 45.5% of doctors discussed the shift to an adult health care provider, and 25.6% received guidance and support in transition to adulthood. The CSHN Program continues to partner with the Center for Community Inclusion Center of Excellence in Disability Studies, Maine Support Network, and the Young Advocators and Educators of Maine (YEA ME) in an effort to increase awareness of the importance of transition planning. The purpose of YEA ME is to provide awareness of youth needs in transition from youth to adult. The YEA ME website is located at http://www.umaine.edu/cci/service/maineworks/youth.

Youth and young adults continue to present YOUTHSPEAK to various providers across Maine and at National conferences. YEA ME members and MaineWorks for Youth staff presented the following presentations in Maine:

YouthSpeak: What We Want Our Teachers to Know. At a Teacher's workshop. Princeton, 05/2005.
Maine Works for Youth! At Mission Transition, Maine Committee on Transition's Transition Fair. Augusta, 04/2005.
YouthSpeak: What We Want Our Health Care Providers to Know. At Maine-Dartmouth Family Residency Program. Augusta, 04/2005.
YouthSpeak: What We Want Our Health Care Providers to Know. At Husson College to Occupational Therapy students. Bangor, 11/2004.
YouthSpeak: What We Want Our Teachers to Know. To Counselor Education students at UMaine. 10/2004.
Youth In Transition. At Everyone Can Work, Maine APSE Conference. Lewiston, 10/2004.
Maine Works for Youth! Service Tapestry. At the Learning Disabilities Association ME Resource Fair. Oakland, 10/2004.
Maine Works for Youth! Service Tapestry. To State of Maine Vocational Rehabilitation Counselors, Augusta, 09/2004.
Know Your Disability. At Maine Committee on Transition Youth Leadership Retreat, Rome, 09/2004.
Youth Panel Presentation. At KIDS Law 2004 Annual Conference. Augusta, 06/2004.
YEA Panel Presentation. At Special Family Weekend. Maine Maritime Academy. 06/04.

Leadership and Innovation to Enhance Quality Care and Transition: YOUTHSPEAK in Maine presented at the Pac Rim Conference, Honolulu, HI. 3/2005.

YEA ME members continue to meet six times per year to discuss and take action on topics that impact their lives. For example, YEA ME met with the Maine Legislative Youth Advisory Council (advise State Legislators on youth issues) to discuss the difficult and often confusing path youth with disabilities must follow in order to obtain a Maine driver's license. It was painfully evident to the Youth Legislators that what they consider as a right of passage to adulthood is often marred with roadblocks for youth with special health needs. YEA ME expressed the difficulty in locating agencies that have accessible vehicles and instructors trained in the use of adaptive equipment and agencies that teach driver's education to youth with disabilities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Elected Brian Harnish as the Co-chair of YEA ME		X		X
2. Youth are recognized as an integral part of policy and decision making across MCH Programs		X		X
3. YEA ME website complete http://www.umaine.edu/cci/service/maineworks/yeame/		X		X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

YEA ME is in the process of completing "Roadmap to Success: What We Have Learned Along the Way." YEA ME members created this informative resource to help youth with special health needs and/or disabilities identify needs, and address the challenges of moving into adulthood. Topics include; understanding your disability or special health need; developing advocacy skills; and learning how to navigate the service system.

Although funding for Healthy and Ready to Work, MaineWorks for Youth ends June 2005 the CSHN Program plans to continue to incorporate all activities, including stipends and mileage reimbursement into the Maternal and Child Health Block Grant.

c. Plan for the Coming Year

YEA ME is interested in pursuing activities they feel are central to youth initiatives, such as participating on committees with a youth focus. For example, the Children's Cabinet is planning to work on youth transition issues. YEA ME is interested in being involved to ensure the Children's Cabinet initiatives are driven by the needs of youth and young adults.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	78	77	78	72
Annual Indicator	76	75	80.7	78.6	78.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	81	82	83	84

Notes - 2002

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Reporting for 1998-2002 is based on the National Immunization Survey 4:3:1:3:3 series. The 2002 indicator of 80.7% for Maine is not statistically significantly different from the national value of 74.8%. (Note: The 2002 indicator was corrected for the FY06 block grant application; the value reported in prior applications was incorrect.)

Notes - 2003

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Reporting for 1998-2003 is based on the National Immunization Survey 4:3:1:3:3 series. The 2003 indicator of 78.6% for Maine is not statistically significantly different from the national value of 79.4%. (Note: The 2002 and 2003 indicators were corrected for the FY06 block grant application; the values reported in prior applications were incorrect.)

Notes - 2004

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Reporting for 1998-2004 is based on the National Immunization Survey 4:3:1:3:3 series. The 2004 indicator of 78.6% for Maine is the value from the 2003 survey; 2004 data are not yet available. The value for Maine is not statistically significantly different from the national value of 79.4% (also from 2003). (Note: The 2002 and 2003 indicators were corrected for the FY06 block grant application; the values reported in prior applications were incorrect.)

a. Last Year's Accomplishments

Maine's childhood immunization data is obtained from the National Immunization Survey (NIS), a continuing nationwide sample survey conducted among families with children 19-35 months of age and their healthcare providers.

/2006/ Since the 2004 block grant submission, the 2002 4:3:1:3:3 percentage was revised to 80.7% of 19 to 35 month olds. In 2003 Maine achieved 78.6% for the 4:3:1:3:3 immunization series. This continues a gradual decrease since 1998. No particular issue emerges as being responsible for the decreased level of immunizations, rather a series of issues appear to be present. Between 1999 and 2003 a significant portion of program resources were focused on the development of the ImmPact immunization registry with less available for provider education. In addition, the Maine Immunization Program (MIP) centralized its staff from contracts on the county level to staff centrally located in the capitol (Augusta). This resulted in some communities without readily available educational resources. Finally the MIP experienced decreased staffing levels through resignations and delays in filling vacancies due to the hiring freeze. Currently the MIP is in the process of hiring a new provider educator and received approval to fill the last remaining vacancy.

Recently a committee of the Maine Chapter of the American Academy of Pediatricians became aware of the decreasing rate of immunizations. The committee is studying ways pediatricians can contribute to increasing overall immunization rates. //2006//

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to conduct CASA survey for the Immunization Program			X	

2. Continue to provide education and guidance regarding best practice and quality assurance/improvement				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Public Health Nursing, under an agreement with the Maine Immunization Program (MIP), continues to audit assigned medical care practices in Maine to assess the 2-year old immunization rates for the state, as well as, to assess and offer education related to the storage of vaccines supplied by the MIP. For CY 2004, 100 medical provider practices received a full CASA audit, which included both a review of records, as well as, a Vaccine for Children (VFC) assessment. An additional 144 practices received a VFC assessment and education related to the handling of vaccines. One or more of the 20 PHN staff nurses and a supervisor working on this project visited a total of 244 medical practices.

c. Plan for the Coming Year

Public Health Nursing will continue to conduct the CASA survey in FY06.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	13.1	13	12.9	12.8	12.6
Annual Indicator	13.5	11.8	11.5	12.4	
Numerator	360	320	314	339	
Denominator	26618	27040	27209	27319	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.3	12.2	12.1	12	12

Notes - 2002

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

The 2002 indicator was updated at the time of the FY06 block grant application due to revision of the population estimate (used in the denominator) by the Office of Data, Research and Vital Statistics, Maine Bureau of Health. The previously-reported value for 2002 was 12.6.

Based on data from countries with the lowest teen birth rates in the world, we chose an objective for 2008-2009 of 12 per 1,000.

Notes - 2003

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Based on data from countries with the lowest teen birth rates in the world, we chose an objective for 2008-2009 of 12 per 1,000.

Notes - 2004

Preliminary 2004 birth rates will be available in early 2006.

a. Last Year's Accomplishments

The strategies for this measure and SPM # 2 overlap considerably. To reduce duplication activities are not repeated.

Community outreach education through the Family Planning Association of Maine continued in FY04 as in 2003 with increased focus on building relationships with other community organizations and business. The program worked in 32 priority communities with 236 community organizations, 200 businesses, and 33 community coalitions, reaching over 8,400 adults and 11,124 teens in 2004. These numbers represent increases over 2003 in all areas resulting from increased connections built on by outreach educators since the project began in 2000.

Family Planning Clinical services also increased, serving 32,045 clients including 9,908 teens, and increased numbers of poorer and uninsured clients. Evaluation efforts in FY04 focused on continued use of contraceptives in returning clients, and use of condoms, emergency contraceptive accessibility, and chlamydia testing. Results in all areas varied by site and quality improvement activities were initiated to identify why. A planning process in one rural School-based Health Center (SBHC) resulted in full family planning services offered there, while one rural SBHC opened with full services, doubling the number of SBHCs offering comprehensive reproductive health services.

In FY04 Family Life Education Consultants provided consultation for 91 schools and 474 educators. 32 priority schools received in-depth technical assistance. Decreases in these services reflected significant budget and personnel cuts as a result of continued state budget cuts in the overall funding for this program. Nevertheless our evaluation system demonstrated that the priority schools moved forward in the curriculum adoption process an average of 7.3 steps in a 15-step process developed by Maine's Department of Education (DOE). (Included in Appendix) This process moves school districts from forming an inclusive committee, through research, resource gathering, curriculum development to teacher training, implementation and assessment, and represents an increase over FY03. An RFP was issued and an award made to develop a new media campaign directed at parents of adolescents encouraging conversations about sexuality and abstinence. Funding is available through Section 510 Abstinence Education funds. The contractor conducted research on parents knowledge, attitudes, beliefs, and skills, and began developing TV and website resources on the theme "Parent Matter."

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Clinical Services	X			
2. Community-based pregnancy prevention and family planning outreach		X	X	X
3. Comprehensive Family Life Education consultation			X	X
4. Abstinence only media campaign			X	
5. SBHC base funding, technical assistance and standards implementation				X
6. Youth involvement and leadership technical support, training, and networking				X
7.				
8.				
9.				
10.				

b. Current Activities

In addition to providing clinical services for family planning, the Family Planning Association of Maine (FPAM) is also leading a number of initiatives. For example a grant from a local health care conversion foundation (Maine Health Access Foundation) is funding the implementation of Maine's new Emergency Contraception law. This effort is led by the FPAM in consultation with the Board of Pharmacy and with assistance from the Bureau of Health (BOH). A new Title X data system will make tracking condom use, as a secondary method, more difficult but this effort in increasing the use of condoms (a Healthy Maine 2010 objective) continues. We are evaluating continuing contraceptive use among existing clients and monitoring chlamydia testing rates, since we now have a cap of free tests available through Maine's HIV/STD Program.

Additional SBHCs are learning from the planning experience of other SBHCs and considering expanding reproductive health services. In addition, the BOH is continuing to provide technical assistance and other in-kind support to the Maine Assembly on School Based Health Care which received a Kellog Foundation grant in FY04 to increase community involvement and state capacity in SBHCs.

In FY05, consultation and technical assistance, based on the teen pregnancy rates and readiness of the school to address Family Life Education as part of a comprehensive school health education curriculum, continued to be provided to 32 priority schools, and progress in curriculum development and implementation is being tracked. Community Outreach Educators are working with both community organizations and directly with youth to expand awareness, knowledge, and skills, and to supplement the efforts in schools.

The Teen and Young Adult Health Program (TYAHP) worked with the DOE, HIV Educator, the Maine HIV/STD Program, and the Behavioral and Developmental Services Mental Retardation Services to improve sexuality education for students with special needs. A planning process for integration of some pregnancy and STD/HIV prevention efforts was initiated with technical support from the Association of Maternal and Child Health Programs. Lack of additional resources is likely to limit the extent of this project.

The TV media campaign, "Parent Matter" ran statewide in one flight in the fall of 2004 and in one flight in the north-central region of the state in the spring of 2005. A website (www.parentsmatter.org) supplemented the TV campaign and remains as a resource.

c. Plan for the Coming Year

The Bureau of Health continues to maintain the programs described under current activities with the exception of the "Parents Matter" media campaign, as Maine is no longer receiving Abstinence Education funding. Many service numbers are not anticipated to increase and may decrease slightly in some areas due to Federal and State budget restraints. In FY 06 a new request for proposals for Family Planning, Family Life Education and Community Education and Outreach will be issued. The Teen and Young Adult Health Program will be planning for this next round of competitive bidding for state funding.

The Bureau of Health will continue to support 19 SBHCs in the form of grants and technical support and encourage comprehensive services. These grants are due to go out to bid in 2006.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	50	52	55	34
Annual Indicator	48	10.2	34.1	22.7	56.6
Numerator		1207	2009	1405	636
Denominator		11822	5895	6194	1123
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56.6	58	58	60	60

Notes - 2002

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The indicator of 10.2 % for the calendar year 2001 is the percent of Medicaid eligible children, ages 7-9, who had at least one sealant placed on a permanent molar tooth. The indicator for 1999 was derived from the 1999 Smile Survey and refers to the proportion of third graders screened who had at least one dental sealant present. Indicators for 1998 and 2000 are estimates based on the Smile Survey. Because the Smile Survey has not been repeated since 1999, we changed our data source for 2001 to Medicaid eligible children. Dental services reported by Medicaid are provided by a dental provider under category of service described as dental services. Any dental services provided by Emertency Rooms are not included. Due to Claims Bundling by Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics, dental services are mixed with medical services and can not be

separated by claims data analysis. Therefore, the annual indicator is artificially low. What we report reflects any time that a dental service claim includes a procedure code for sealants and the tooth number is a permanent molar. Therefore, we believe that the 10.2 %indicator is extremely low. We look forward to the time when the Smile Survey or a similar survey can be reinstituted. Projected objectives are extremely difficult to estimate based on the Medicaid data.

Notes - 2003

The indicator of 34.1 in calendar year 2002 and 22.7 in calendar year 2003 is the percent of Medicaid eligible children ages 8 to 9 years of age who had at least one sealant placed on a permanent tooth. Of note is that the procedural coding by dental offices is inconsistent. This influences the ability to determine how many children received sealants (Code D1351) and may partly explain the variation from 2002 to 2003. The data does not include children who received dental care through a provider approved for claims bundling such as a federally qualified health center (FQHC) or a rural health center (RHC). The result is an under reporting of children insured through MaineCare who receive any dental services including sealants. The reduction from 2002 to 2003 may also be due to increased number of dental provider organizations that were approved for claims bundling. Prior to 2001, the indicators for this objective came from the 1999 Smile Survey. Due to the infrequency of the Smile Survey, we chose the Medicaid population for this indicator.

Notes - 2004

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The 2004 indicator reflects 3rd grade data from the 2003-2004 Maine Child Health Survey. Data were not weighted due to a low response rate (17.6% for kindergarten and 3rd grade combined). A total of 1234 3rd graders participated in the survey; sealant status was not obtained for 111 (9.0%) of these children. The results reported here are for the 1123 children for whom sealant status was known. Due to the low response rate and high percentage of missing sealant statuses, the results should not be considered generalizable to all 3rd graders in Maine.

The 2001-2003 indicators reflect the percentage of Medicaid-eligible children ages 8 to 9 years who had at least one sealant placed on a permanent tooth. Of note is that the procedural coding by dental offices is inconsistent. This influences the ability to determine how many children received sealants (Code D1351) and may partly explain the variation from 2002 to 2003. The data does not include children who received dental care through a provider approved for claims bundling such as a federally qualified health center (FQHC) or a rural health center (RHC). The result is an under reporting of children insured through MaineCare who receive any dental services including sealants. The reduction from 2002 to 2003 may also be due to increased number of dental provider organizations that were approved for claims bundling.

Prior to 2001, the indicators for this objective came from the 1999 Smile Survey.

a. Last Year's Accomplishments

The Oral Health Program (OHP) continues to support and expand the voluntary dental sealant component of its School Oral Health Program (SOHP) that supports classroom-based education and fluoride mouthrinse programs.
/2006/The sealant component began in 1998-1999 with 22 schools providing sealants for 403 students. For the 2003-2004 school year, 121 individual schools had sealant components, providing 4,596 sealants to 1,462 children (an average of 3.14 sealants each). The retention rate was 92%. Complete data for the 2004-2005 school year, is not yet available. In this school year, 123 schools have dental sealant programs. //2006//

In August 2002, the Centers for Disease Control and Prevention (CDC) awarded a one-year

cost extension to the OHPs School Oral Health Infrastructure Grant. As noted previously, the new funding supported further analysis and implementation of the findings of the SOHP evaluation conducted during the previous academic year. As a result of that evaluation, revised SOHP Eligibility Guidelines were developed and incorporated into the application process for schools for the 5-year grant cycle beginning July 1, 2003. In addition, under the extension, we developed a sustainability plan by identifying alternative billing procedures for reimbursement of preventive dental services provided through the SOHP.
/2006/ At present, a limited number of school sealant programs receive reimbursement from MaineCare and will be expanded over time. //2006//

Grants for general support using the state match to the Maternal and Child Health Block Grant (MCHBG) continue to be made to three community agencies that provide clinical dental services to at-risk children.
/2006/ Comparably to last year, at least 1,675 children received sealants through these clinics; the number of third graders is not available. This support assisted those clinics in providing about 19,500 dental visits during the reporting year to approximately 14,800 individuals. Most were under age 21. //2006//

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain and increase the number of schools with sealant programs	X		X	
2. Evaluate plan and continue implementation of database for sealant program data collection		X		X
3. Continue as MaineCare provider for sealants				X
4. Analyze and report on 2004 Smile Survey data and plan for sustainability of Statewide Smile Survey as component of Maine Child Health Survey			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 2004 Smile Survey was conducted as part of the Maine Child Health Survey (MCHS) in collaboration with the Maine Asthma Prevention and Control Program. Data for the Oral Health section of the MCHS was submitted to an oral epidemiologist who, via an agreement with the Association of State and Territorial Dental Directors (ASTDD), will fully analyze the data and provide a technical report that is expected later this summer. Analysis was delayed due to changes in the 2004-2005 workplan for the Bureau of Health (BOH) epidemiologist working on the MCHS. A recent analysis of survey response patterns resulted in postponement of the MCHS planned for the 2005-2006 school year while BOH staff evaluate the process, resources required, and resulting outcomes of the survey. School personnel will be invited to be involved in the evaluation.

Our application to the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB) under the State Oral Health Collaborative Systems Grant

Program was funded for three years starting in September of 2004. The grant will support the development of a state Oral Health Advisory Committee to work with the OHP. Its first task is to develop a state oral health improvement plan for Maine.

The staff hygienist left the OHP in September 2004 and the position remains vacant. Recruitment is underway to fill the position. This extended vacancy has imposed constraints on overall program activity. In addition, another position has been vacant for all but three months since March 2004, and cannot be filled until the incumbent's extended medical leave ends. These two vacancies severely limit the ability of remaining staff to undertake new initiatives.

c. Plan for the Coming Year

The OHP will continue to encourage inclusion of sealant components in the SOHP, and the number of schools is expected to continue to grow pending the availability of funding. Our experience as a MaineCare provider will continue to be monitored, and expanded within staffing and technology constraints.

The Advisory Committee will also be involved, as appropriate, with the implementation and evaluation of the oral health data and surveillance system, the continued inclusion of an oral health component in the Maine Child Health Survey, and the role of a broad-based stakeholder group, based on the existing Maine Dental Access Coalition. These activities support increasing the proportion of Maine third-graders who receive sealants, and our ability to track the data and evaluate the program, as well as other initiatives of the OHP. Continued staff vacancies in the OHP and resulting staffing constraints, delayed implementation of the projected activities, and the Committee's work is just beginning.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.7	3.7	3.6	3.5	3.5
Annual Indicator	3.7	2.9	3.1	3.4	
Numerator	43	34	37	41	
Denominator	1166447	1167011	1212050	1195448	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.2	3	3	3	3

Notes - 2002

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per

100,000 children.

The 2002 indicator is the 5-year average for 1998-2002. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation. (Note: The 2002 indicator was updated at the time of the FY06 block grant application due to revision of both numerator and denominator values by the Office of Data, Research and Vital Statistics, Maine Bureau of Health. The previously-reported value for 2002 was 3.0.)

Notes - 2003

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

The 2003 indicator is the 5-year average for 1999-2003. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Notes - 2004

2004 data are not yet available.

a. Last Year's Accomplishments

The number of Child Safety Seat Loan Program sites fluctuated between 37 and 41 during the reporting period due to changes or loss in staff at sites, new sites or site closures. Demand for booster seats began to level off during the second half of FY04, but demand for infant toddler seats remained high. The program distributed a total of 2,452 infant/toddler seats, high back booster seats, no back booster/convertible seats, and special need seats. Special needs seats include seats for children too small or too large for standard seats, harness systems for children with behavioral issues, and specially constructed seats for children with health related issues. The percentage of booster seats changed from 36 percent of all seats supplied in the first half of the fiscal period (June-December 2003) to 28 percent of all seats supplied in the second half of fiscal year (January -- June 2004). The demand for booster seats increased after the Booster Seat Law went into effecting January of 2003 as families were accustomed to securing their children with seat belts and did not own a booster seat. Over time the backlog of families with children, 4-8 years old, needing booster seats was filled resulting in more normal requests for booster seats as children outgrew their car seats.

The Traffic Safety Educator (TSE) position was filled in November 2003. Although the new TSE was a certified Child Passenger Safety Technician (CPST), certification as a CPST Instructor was required. She completed her training in June of 2004. The TSE began making site visits in January of 2004 and the Annual Child Safety Seat Site Manager Workshops were held in April of 2004. The TSE developed a child passenger safety (CPS) Newsletter that was initially sent to program site managers, with distribution expanded to include all CPS technicians in Maine, as well as, the National Highway Transportation Safety Administration Regional CPS office and the Maine Legislature Transportation Committee.

Two National Highway Traffic Safety Administration (NHTSA) classes were scheduled, one in Ellsworth in November of 2003, the other in Lincoln in April of 2004. Six CPS technicians were trained at the Ellsworth class, but the April class in Lincoln was cancelled due to low enrollment. Fourteen CPS technicians including the TSE were trained in special needs for child passenger safety in Waterville in May of 2004.

The program continues to provide technical assistance to members of the public who call requesting information on car seats.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide child safety and booster seats to children birth to 8 years old	X	X	X	X
2. Provide training for Child Passenger Safety Technicians		X		X
3. Continue to present to groups and organizations on the importance of child passenger safety		X		X
4. Continue to monitor impact of Booster Seat Law			X	
5. Provide support and education to fitting stations				X
6. Collect data on mis-use and number of seat checks				X
7.				
8.				
9.				
10.				

b. Current Activities

More than 33,000 (not including the Buckle Me Up Moose Stickers and Help ME Bike Safely bike helmet stickers) pieces of injury prevention promotional materials related to traffic safety were distributed to organizations throughout the state. The TSE conducted a NHTSA Child Passenger Safety Technician class in Gardiner in September of 2004. Plans for a second class in Bangor in June, and a one-day CPST re-certification class for June 2005 are underway. A four hour CPS awareness training for health care workers in Calais April 23, 2004, Caribou August 26, 2004, and public health nurses in Region III in Houlton, August 27, 2004, a six-hour CPS awareness training for DHHS employees in Augusta November 16, 2004 were conducted with plans to repeat the training in Bangor and Portland during the spring of 2005. The TSE developed program posters and brochures and distributed to sites. Annual Child Safety Seat Site Manager workshops are planned for four regional locations in the spring of 2005. The TSE visited every voucher site at least one time and remains in close contact with the sites through e-mail and telephone.

c. Plan for the Coming Year

MIPP will continue the following activities during FY06.
1. Provide child safety seats and technical assistance to safety seat programs statewide. Provide at least 1600 infant/toddler seats 800 booster seats and 400 special needs seats.
2. Continue to monitor the impact of the Booster Seat Law through baseline data obtained from Crash Outcome Data and Evaluation System (CODES) and the Maine Child Health Survey.
3. Continue to work with the media and legislators to educate the public on child passenger safety issues.
4. Provide annual child passenger safety training to Child Passenger Safety Seat program staff in at various locations around the state.
5. Provide at least one daylong Child Passenger Safety (CPS) Technician re-certification class for certified CPS Technicians.
6. Provide child passenger safety technician training based on the National Highway Traffic Safety Administration, child passenger safety standardized curriculum.
7. Continue to provide educational materials and resources on child passenger safety to professionals, advocates and the general public.
8. Maintain a list of Child Passenger Safety Technicians available to assist parents and caregivers on the proper use of child restraint systems in communities throughout Maine.
9. The program will develop and maintain a Web site for dissemination of prevention information including prevention resource contacts, data, training opportunities and links to

other Maine and national injury prevention resources.
10. MIPP will continue to collaborate and coordinate on occupant protection safety issues with the Maine Transportation Safety Coalition as well as other committees, and state agencies involved in protecting the safety of Maine's young drivers.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	65	67	65	65	66
Annual Indicator	64.0	63.3	60.5	60.1	61.4
Numerator	8678	8589	8072	7870	8055
Denominator	13559	13566	13336	13097	13119
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62	63	64	65	66

Notes - 2002

Percentage of mothers who breastfeed their infants at hospital discharge.

The indicator of 63.3 % is for calendar year 2001. The rate reflects infants exclusively breastfed at hospital discharge This figure does not include infants who were breast and bottle fed. The data source is newborn screening blood spot filter paper specimen. Thus, the denominator is the number of occurrent births.

The measure shows a slight increase from 1998 to 2001. While Maine's rates are lower than those of some other states, many of those states do not report using a measure of exclusive breastfeeding.

Notes - 2003

The indicators of 60.5 and 60.1 are for calendar years 2002 and 2003 respectively. The rate reflects exclusively breastfed newborns at hospital discharge. This figure does not include the infants who were breast and bottle fed. The data source is the bloodspot filter paper newborn screening specimen. Thus, the denominator is the number of births that take place in Maine. The indicator shows a slight decrease from prior years. While Maine's rates are lower than those of some other states, many of those states do not report using a measure of exclusive breastfeeding.

Notes - 2004

Percentage of mothers who breastfeed their infants at hospital discharge.

Indicator is based on feeding method noted on newborn bloodspot filter papers. Beginning in 2004, the indicator reflects those newborns for whom feeding method was known. In 2004, feeding method was known for 13,119 (96.1%) of the 13,709 occurrent births.

a. Last Year's Accomplishments

Our most accurate data source for breastfeeding rates at hospital discharge continues to come from the newborn screening filter paper forms. Information collected at the time of newborn screening, near or at the time of hospital discharge during CY 2003 show the following data on method of feeding. Of the 13,356 infants who received a newborn screen, 8,072 were exclusively breastfed (60.4%), 4,722 were formula fed (35.3%). Only two infants were reported to receive both breast milk and formula and 3.4% of infants had no feeding method documented.

/2006/The data is consistent with previous years. Of the 13,650 infants who received a newborn bloodspot screen and indicated a feeding method (13,119) on the filter paper form, 61.4% or 8,055 were breastfed and 4,970 37.9% received formula. 1 infant was reported to receive both breast milk and formula. Removing those infants with an unknown feeding method only slightly increased the breastfeeding rate. //2006//

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluate data source and improve accuracy of reporting of feeding method				X
2. Continue increasing capacity for support of breastfeeding through Breastfeeding Counselors				X
3. Continue specified education to prenatal and postnatal service providers		X		
4. Continue work with Loving Support Campaign				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WIC, Public and Community Health Nursing Programs continue to increase and strengthen the resources available to support new mothers in breastfeeding their babies. Public Health Nursing (PHN) staff in Kennebec and Somerset County attend WIC infant feeding class when available to discuss services they can provide during pregnancy and postpartum support of breastfeeding. In addition, WIC discusses breastfeeding at each prenatal visit. PHN works with standardized nursing interventions addressing breastfeeding in prenatal and postpartum client individualized plan of care. The interventions include health teaching, guidance and counseling, surveillance and case management. PHN breastfeeding resource nurses are active in their local breastfeeding coalitions, involved in community fairs, are a resource for reference materials on breastfeeding, collaborate with WIC on developing a brochure.

c. Plan for the Coming Year

The Genetics Program will continue to promote complete and accurate information on the filter

paper forms. Breastfeeding rates will be a topic included in an upcoming Genetics and Newborn Screening newsletter distributed to providers and others. This article will encourage accurate and complete information on the filter paper forms in order to assure accurate reflection of hospital efforts to promote breastfeeding.

The WIC Program will continue sponsoring opportunities to increase the number of Certified Lactation Counselors (CLC). The WIC, Public and Community Health Nursing Programs will continue to provide education and support specific to breastfeeding for prenatal and postpartum women and their families.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45	82	92	95	75
Annual Indicator	79.6	80.3	91.4	98.4	89.1
Numerator	10821	10894	12194	12883	12208
Denominator	13590	13566	13336	13097	13709
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	91	92	93	94

Notes - 2002

Percentage of newborns who have been screened for hearing before hospital discharge.

The indicator of 80 % is for the calendar year 2001. No data are available until 1997. The data from 1997-2002 represent the percent of newborns who had ACCESS to screening, not the percent of newborns actually screened. The increasing percentage of newborns who had ACCESS reflects increases in the number of hospitals that have screening equipment in place. By 2004, we will be able to assess the actual percentage of newborns screened. Objectives for 2002 and 2003 are based on access. The subsequent objectives for 2004-2007 reflect reasonable estimates for the percentage of infants who actually will be screened.

Notes - 2003

Please note that the measure reported here is the percentage of newborns who have access to a hearing screen before hospital discharge.

The indicator of 98.4 % is for the calendar year 2003. No data are available until 1997. The data from 1997-2003 represent the percent of newborns who had ACCESS to screening, not the percent of newborns actually screened. The increasing percentage of newborns who had

ACCESS reflects increases in the number of hospitals that have screening equipment in place. By 2004, we will be able to assess the actual percentage of newborns screened. Objectives for 2002 and 2003 are based on access. The subsequent objectives for 2004-2007 reflect reasonable estimates for the percentage of infants who actually will be screened.

Notes - 2004

For 2003 and prior years, this indicator reflected the percentage of newborns who had *access* to a hearing screen before hospital discharge. Beginning in 2004, the indicator reflects the percentage of newborns that were actually screened. The 89.1% indicator for 2004 is, however, an underestimate, since the two largest hospitals did not fully capture data during the transition to the new electronic reporting system. It is estimated that the true percentage of newborns screened was approximately 97%. (It is assumed that the remaining 3% were the result of parental refusal, home births not screened, or infants who died before screening.)

a. Last Year's Accomplishments

By December, 2003, 100% of hospitals had hearing screening equipment and were offering newborn hearing screening prior to discharge as a standard of newborn care. Hospitals inform primary care providers of the results of newborn hearing screening and collaborate with primary care providers to schedule an appointment for audiological evaluation for infants who screen positive (refer result).

Hospitals voluntarily reported aggregate results to the Maine Newborn Hearing Program (MNHP) via paper survey. Of the hospitals with established hearing screening programs, reports indicate that >95% of babies were screened and refer results reported to be less than 4%.

Audiologists were surveyed in 2003 to determine capacity. Survey results indicated that 19 audiological facilities provide infants and young children with audiological test evaluations. 6 facilities indicated they could provide the complete panel of testing necessary for a presumptive diagnosis of hearing loss and the remaining 13 could provide some of the testing. A list identifying the audiogical facilities and capacity was distributed statewide to hospitals and providers in fall 2003. MNHP held a workshop to solicit input from the audiological community and establish a collaborative relationship in preparation for voluntary reporting of audiological evaluation results to the MNHP.

As part of an ongoing plan to prepare for a comprehensive data reporting system to track infants for hearing screening, diagnosis and early intervention, a Memorandum of Agreement (MOA) was developed with the University of Maine -- University Center of Excellence in Developmental Disabilities (UM/UCEDD) and the Bureau of Health (BOH). Through this MOA, the BOH participated in development of ChildLINK, a data system capable of integrating other Maternal and Child Health data sets with newborn hearing screening data. ChildLINK allows the integration of information necessary for tracking individual children through hearing screening, identification and intervention.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete enrollment of hospitals into the electronic reporting system and monitor compliance			X	
2. Provide tracking of newborns who do not pass the hospital screen		X		
3. Evaluate comprehensive screening and service syste				X
4. Continue to facilitate the Newborn Hearing Program Advisory Board				X

5. Plan & hold Symposium on Hearing Loss in Infants & Young Children for health care providers, early intervention specialists,educators & parents				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Screening information is currently being obtained electronically from the 11 major hospitals, comprising 61% of all Maine births. All remaining hospitals have completed the informatics infrastructure and are awaiting enrollment during 2005. In the meantime they continue to provide information by paper survey or reports. Successful enrollment of all birth hospitals into the electronic reporting system will enable accurate and timely information needed to successfully track all infants for confirmation of hearing screening and results of hearing screening.

With parental permission, audiologists started reporting the results of audiological evaluations on children up to age three into ChildLINK. Many audiologists are reporting via a web-based system into ChildLINK. Program staff can view the information for tracking and case management activities. A new reporting form was developed to enable reporting the results of evaluation on infants older than 6 months and to enable reporting of hearing aid fittings and cochlear implants on children up to age three.

Competitive applications for continued funding from the Centers for Disease Control and Prevention (CDC) and Health Resources Services Administration/Maternal and Child Health Bureau (HRSA/MCHB) for the MNHP were submitted. Successful funding will enable the continuation of a comprehensive Universal Newborn Hearing Screening and Intervention Program in Maine. Awards will be announced during 2005.

The Maine Newborn Hearing Program Advisory Board, established through statute, provides oversight and advice to the program. Board members meet at least twice per year. During 2005, Board members will participate in the development of a program evaluation plan, development of outcome measures, and mechanisms for collecting reliable and valid data for priority indicators.

c. Plan for the Coming Year

To address awareness about the benefits of newborn hearing screening and early identification, planning began for a large "symposium" to provide a broad range of education to families, audiologists and providers. The focus of this symposium is on timely screening, diagnosis, counseling families and appropriate early intervention and outcome indicators for young children with hearing loss.

Tracking of individual infants and children will be comprehensive during FY06. Families and providers will be contacted throughout the early hearing detection and intervention (EHDI) process for confirmation of hearing screening, audiological follow-up and enrollment into early intervention.

While many audiologists report the results of audiogical evaluation, there is no mandate to report. A legislative mandate will allow audiologists to report consistently. Consistent reporting of audiological evaluation results are needed on all infants referred from hospital newborn

hearing screening for appropriate and timely follow-up.

An identified challenge is with infants who reside in Maine but receive hearing screening or audiological services in bordering New England states such as New Hampshire and Massachusetts. Plans are in process for the development of an MOA between those states that border Maine. The MOA will detail data sharing. Development of this MOA will assist in tracking and follow-up of all babies born in Maine, or whose mothers live in Maine, regardless of state borders.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9.7	6	6	10	10
Annual Indicator	6.0	6.0	6.7	7	
Numerator	19130	19130			
Denominator	318835	318835			
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	10	10

Notes - 2002

Percent of children without health insurance (Capacity)

The preliminary indicator of 7.6 % is for the calendar year 2002. The indicators from 1998 to 2002 are derived from three random telephone surveys carried out by Mathematica in partnership with the Muskie School of Public Service at the University of Southern Maine. The 1998 indicator of 9.7 % and the corresponding 1999 estimate are based on a telephone survey done in 1997. The 2000 indicator of 6 % and the estimate for 2001 are based on a replication of the 1997 survey carried out between January and June 2000. The preliminary indicator of 7.6 %, from a third survey between January and June 2002, suggests a slight increase in the % of uninsured children. We hypothesize that this increase reflects economic factors, and our objective of 10 % by 2007 is influenced by persisting economic uncertainty mixed with anticipated benefits from Maine's new health care reform, Dirigo Health Plan.

Notes - 2003

Percent of children without health insurance.

The 2003 indicator reflects analysis of 2002-2003 state data from the pooled 2003 and 2004 Current Population Surveys conducted by the Kaiser Family Foundation and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

2002: Indicator is derived from the Maine Child Health Survey for kindergarten age children. Interestingly, the 6.7 % estimated uninsured kindergartners from the Maine Child Survey sample is close to the 5.9 % of children birth to 5 estimated to be uninsured from a Year 2000 survey titled, "Health Insurance Coverage Among Maine's Children" (Ormand C., Salley S., Kilbreth E., 2000).

1999-2001: Indicators derived from random telephone surveys carried out by Mathematica in partnership with the Muskie School of Public Service at the University of Southern Maine.

Our objective of 10 % by 2009 is influenced by persisting economic uncertainty mixed with anticipated benefits from Maine's new health care reform, Dirigo Health Plan.

Notes - 2004

Percent of children without health insurance.

2004 data are not yet available.

a. Last Year's Accomplishments

In FY04, over 10,000 students received services at school-based health centers (SBHCs) in Maine, an increase of 20% in the last year alone, due to two new SBHCs receiving grants, to expansions in scope of services and in enrollment. SBHCs are also conducting outreach to community health providers to educate them about SBHC services and to coordinate care with primary care providers. Protocols to strengthen the relationship between primary care providers and SBHCs are in place. Reimbursement from Private insurers increased with the start of the Pilot study in FY04, and claims data, as well as, survey data was collected for the first year of this 3 year study. A SBHC sustainability study was conducted and nineteen key factors to SBHC sustainability were identified. The Bureau of Health (BOH), individual SBHCs, and the Maine Assembly on School Based Health Care (MeASBHC) reviewed the recommendations together and identified roles for increasing sustainability. MeASBHC received a Kellogg Foundation grant to increase SBHC sustainability through community involvement and mobilization. The BOH is an active partner is this grant, and sees this private-public partnership as an important piece of infrastructure for SBHC sustainability.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SBHC providing assessment of insurance status, education and assistance in enrollment		X		
2. SBHC insurance pilot study				X
3. Monitor changes in insurance coverage			X	
4. Monitor for changes in MaineCare services and work with the BMS to facilitate MaineCare reimbursement for adolescent health services				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Linkages with medical homes and insurance continued in SBHCs in FY04. In 2001, a collaborative project with the major health plans in Maine was initiated to measure cost-effectiveness of private insurers covering SBHC services. In FY05, fifteen SBHCs, continue to participate in this pilot project. Funding from the Maine Health Access Foundation is supporting the evaluation of this project for the first two years, and the partners continue to seek additional funding. The BOH continues actively working with the Bureau of Medical Services (BMS) to improve the reimbursement processes for MaineCare. Base-funding from state Maternal and Child Health Block Grant (MCHBG) matching funds and the Fund for a Healthy Maine (Master Tobacco Settlement funds) for 19 SBHCs is helping to maintain access to services as the SBHCs and sponsoring agencies face more stringent budgets.

Budget constraints have limited the expansion of MaineCare to childless adults and demanded a number of coverage cuts, mostly for adults. However, enrollment in the Governor's Dirigo Health Plan began in January 2005. This is part of a comprehensive plan to increase access to health insurance. It consists of comprehensive and affordable health coverage offered through private insurers to part and full-time employees who work in small businesses and are self-employed, as well as, to individuals without health insurance. Employees not eligible for MaineCare can purchase insurance on a sliding scale based on ability to pay if their income is below 300% FPL. In addition, employees in self-insured businesses are eligible to have a portion of their premium subsidized. The uninsured with incomes over 300% of poverty can purchase their coverage at cost. Funding sources include employer, employee, state and federal, which are pooled to lower health care costs.

c. Plan for the Coming Year

The Bureau of Health will continue to work with SBHCs, MeASBHC, the Maine Children's Alliance, and private insurers to support the Insurance Pilot Study. The BOH continues as an active partner in a Kellogg Foundation grant to increase SBHC sustainability through community involvement and mobilization, including youth involvement and clinical improvement initiatives. Base-funding for 19 SBHCs is helping to maintain access to services as the SBHCs and sponsoring agencies face more stringent budgets. In FY06, the development of a new request for proposals will be written to reissue these funds.

Development of the Dirigo Health plan will continue, focusing on improving health status, cost containment, increasing access, and improving quality of care. Enrollment in the Dirigo Health insurance product is expected to expand further.

The Humane Systems for Early Childhood Grant, through the leadership of the Task Force on Early Childhood of the Governor's Children's Cabinet, will include in its comprehensive plan a series of action steps to expand and enhance health insurance for the young child and family population. The focus will be on setting up systematic changes, for example, to support health care consultants in child care centers and to allow working parents to take children to their medical homes without financial or other employment-related risk.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and	**2000**	**2001**	**2002**	**2003**	**2004**

Performance Data					
Annual Performance Objective	50	84	78	80	79
Annual Indicator	81.9	76.6	77.2	78.4	81.3
Numerator	73712	96256	109463	118870	111523
Denominator	89958	125701	141850	151651	137134
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	83	84	85	86

Notes - 2002

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. (Process)

The latest indicator is for calendar year 2001. The term "potentially Medicaid-eligible" needs to be clarified. Medicaid eligibility is defined as the total number of persons who apply to Medicaid and are found eligible. It does not include uninsured persons. The large increase in the numerator in 2000 reflects a greater understanding by Medicaid of what the data means. Specifically, starting in 2000, Medicaid pulled any claim whatsoever, while prior to 2000, it pulled claims by a combination of category of service and procedure codes. Because FQHC's, RHC's, and ambulatory hospital based clinics bundle their claims and do not provide procedure codes, the identification of claims by procedure code was not accurate. Also, Medicaid changed its reporting time frame from federal fiscal year 2000 (ending 9/30/00) to calendar year 2001, so that data on the last three months of 2000 are not reported in either year. The HEDIS methodology of using 11 months of continuous eligibility was not used in 2001, nor in the prior 3 years. The denominator is based on children determined to be Medicaid eligible on a month to month basis. If a child is eligible for any one month, he or she is counted for inclusion.The denominator increased in 2001 primarily due to increased enrollment for the Healthy Maine Prescriptions Rx Program. The Dirigo Health Plan, enacted in 2003, and other state initiatives will hopefully increase this indicator as a result of more people being served.

Notes - 2003

The latest indicators are for calendar year 2002 and 2003. The term "potentially Medicaid eligible" needs to be clarified. Medicaid eligibilty is defined as the total number of persons who apply to Medicaid and are found eligible. It does NOT include uninsured persons. The large increase in the numerator from 2000 onward reflects a greater understanding by Medicaid of what the data means. Starting in 2000 the Medicaid agency pulled any claim whatsoever, while prior to 2000 it pulled claims by a combination of category of service and procedure codes. Because FQHCs, RHCs, and ambulatory hospital based practices bundle their claims and do not provide procedure codes, the identification of claims by procedure code was not accurate. The denominator is based on children determined to be Medicaid eligible on a month to month basis, rather than the HEDIS method of using 11 months of continuous eligibility. The denominator had a significant increase in 2001 primarily due to the development of the Healthy Maine Prescriptions Rx Program. Participants in the Healthy Maine Prescriptions Rx Program are only eligible for prescription benefits.

Notes - 2004

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

2004 indicator is for Federal Fiscal Year 2004 (10/1/03-9/30/04). Indicator is for 1-20 year olds.

a. Last Year's Accomplishments

During CY2003 Public Health Nursing (PHN) increased collaboration with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program by assisting children needing services following a well child visit to a primary care provider. PHN worked cooperatively with the Maine Immunization Program (MIP) and the Bureau of Medical Services (BMS) to provide interventions to parents and guardians of children receiving MaineCare benefits. The children were identified as needing additional services or family support in the areas of assistance with referrals for specialty medical care, screenings, developmental services, mental health services, parenting issues, lead screening follow-up, and transportation. During interactions with families public health nurses frequently addressed many other health issues not previously identified. Parents, guardians, and the public health nurses involved in this project reported a greater ability to schedule appointments for children to receive the necessary follow-up care. PHN completed 5,582 EPSDT follow-ups in CY2003 accounting for 2,680 hours of nursing staff time. In 2004, PHN made 3,222 contacts accounting for 2,300 hours of staff time.

During 2004 PHN entered into an agreement with BMS to review and triage all of the Bright Future Periodicity forms generated from medical provider practices. PHN reviewed 27,178 forms for the months of August through December, accounting for 350 hours of PHN staff time.

Use of the home visiting database, created for the evaluation of the Healthy Families, Parents as Teachers, Parents Are Teachers Too, Adolescent Pregnancy and Parenting Programs, started in the first quarter of FY04. Data elements include insurance status, status of well child visits, and immunization status.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PHN continue to work closely with MIP to ensure EPSDT Population receive care	X			
2. Monitor implementation of the two core performance measures in relation to this section				X
3. HF, PAT, PATT, CHN, APP and PHN staff maintain knowledge regarding EPSDT and MaineCare services		X		X
4. HF, PAT, PATT, CHN, PHN, and APP educate and assist clients in applying for and utilizing MaineCare insurance benefits		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In an effort to increase the number of children with insurance coverage, Maine's SCHIP goals are:

/2006/ The goals remain the same. //2006//
1. Collaborate with the Covering Kids and Families Outreach Campaign to provide technical training to staff of community agencies and health care providers, improve quality of technical training provided to staff of community-based agencies, and increase MaineCare participation. The Covering Kids Campaign will end in December of 2005.
2. Improve relevant, desired drug outcomes for designated medical conditions as measured by the percentage of patients on designated drugs, rate of ED/hospital visits, LOS, readmission rates for patients with designated diagnoses. (For this goal the Bureau of Medical Services looks at all children not just those insured through SCHIP.)
3. Increase involvement of members and providers in Health Promotion as measured by the number of providers attending technical training provided by Covering Kids and Families Campaign, EPSDT mailings, and follow-up to all members and quarterly educational newsletters to members and Primary Provider Profile to providers.
4. Provide Quality Care to Members as measured by the increase in member satisfaction and reduction in rate of potentially avoidable hospitalizations.

For children insured through MaineCare PHN continues to assist those needing services following a well child visit.

c. Plan for the Coming Year

PHN will continue to work with the MIP and MaineCare to ensure follow-up services for children identified through well child visits needing additional services.

Monitor home visiting performance measures related to children's insurance and well child care.

Because of severe fiscal restraints in Medicaid, our challenge will be to develop clearly proven, cost-effective strategies to support health care for this group of children. Such strategies include:

1. Continue efforts to strengthen the delivery of oral health services within the medical home, and explore with Medicaid the potential for reimbursing such preventive services.
2. Demonstrate the cost-effectiveness of a comprehensive system of care coordination for children with special health needs, as distinct from the more limited case management model that Medicaid currently offers.
3. Capitalizing on the newly created Maine Department of Health and Human Services (DHHS), strive to integrate mental health services into the medical home for this population.
4. Explore with the Bureau of Medical Services the possibility of creating a Medicaid Prenatal Care Coordination Benefit that reimburses providers for the array of non-medical services and supports that have been shown to improve birth outcomes and reduce costs associated with low birth weight and premature births.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	1	1	1.2	1.2	1.2
Annual Indicator	1.1	1.1	1.1	1.2	1.1
Numerator	733	732	760	791	787
Denominator	68344	68328	68220	68343	68669
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.1	1	1	1	1

Notes - 2002

The percent of very low birth weight infants among all live births.

The latest indicator of 1.1 percent, reported under the column for 2001, represents the five year average for 1997-2001. We report similar 5-year averages going back to 1994-1998 for the column under 1998. This is due to the small number of very low birth weight (VLBW) births. Maine fares quite well compared to other states in its VLBW percentage, as it does for several performance and outcome measures. For the nation as a whole, 1.4% of infants were born with very low birth weight in 2000, compared to Maine's 1.1%. Maine's VLBW percentage has not changed since 1998, and we do not project it to go down any further.

Notes - 2003

The percent of very low birth weight infants among all live births.

The 2003 indicator is the 5-year average for 1999-2003. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Notes - 2004

The percent of very low birth weight infants among all live births.

The 2004 indicator is the 5-year average for 2000-2004. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

a. Last Year's Accomplishments

Maine continues to have a lower percentage of VLBW babies than the nation as a whole.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provision of education and technical assistance to health care providers through Perinatal Outreach		**X**		**X**
2. In depth Epi analysis of factors contributing to VLBW (Will begin when doctoral prepared Epidemiology position is filled in late 2005)				**X**
3. Partner in the Prematurity Prevention Campaign led by the MOD			**X**	**X**
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A recent reduction in neonatal Nurse Practitioners coupled with the call to active duty of the Perinatologist has created a void at the Level III nursery in Bangor. The Portland Level III nursery is assisting in support while the Bangor hospital takes steps to rebuild capacity. In addition, the Lewiston hospital has notified area hospitals that, with the departure of a neonatologist, it can no longer care for infants at less than 32 weeks gestation.
/2006/ Staffing at Eastern Maine Medical Center, Level III Nursery in Bangor is slowly recovering from staffing changes, by recruiting nurses and neonatal nurse practitioners. An experienced neonatologist is expected to join the staff in July 2005. The Central Maine Medical Center in Lewiston continues to limit its scope to pregnant women and neonates beyond 32 weeks gestation. //2006//

During the past 3 years the Title V Program focused on building its capacity in relation to MCH Epidemiology. The development of our Epidemiology team enabled Title V to obtain a greater understanding of the factors contributing to achievement or lack of achievement related to national and state performance measures. Areas worthy of further analysis include anecdotal reports of increased maternal drug use, a gradual diversification of Maine's racial and ethnic population through migration and resettlement of refugee populations, and the impact of assisted reproductive technology.

The Title V Program has been unable to conduct an in-depth analysis of factors contributing to VLBW due to the planned departure of the Ph.D. Maternal Child Health Epidemiologist.

c. Plan for the Coming Year

The Perinatal Substance Abuse Prevention Work Group, chaired by the MCH Medical Director and the Perinatal Nurse Manager, continued to grow within the past year. It now consists of an established network of about 50 people from a wide array of public and private, prevention and treatment, and state and local organizations and from all walks of life who are committed to address this issue in a humane and culturally competent manner.

The group has focused broadly on how to develop a united and humane approach to perinatal addiction. A common theme that emerges from this multi-disciplinary group is that being humane in the way we design and carry out perinatal addiction prevention and treatment means that we must move away from a punitive approach. When we are humane, we are non-punitive and non-judgmental. We respect substance abuse as an illness with opportunities for healing and recovery. Humane prevention and treatment is resiliency-based and respectful of all cultures. We tap into the resources and strengths and resiliency of the mothers, infants, and their families, knowing that the vast majority of mothers have within them the motivation for change.

Dialogue has also focused on the new federal requirement that all infants who show evidence of maternal drug exposure be reported to Child Protection Services. The group has engaged state level child protection colleagues in an initial dialogue on this matter, and plan to have a statewide symposium in 2006 that, among other aspects of perinatal addiction, specifically addresses the implications of this new requirement.

Another focus of the perinatal addiction group is the sharing of updates on various grants and the subsequent increase in collaboration that results from such sharing. Examples include 1) The Federal SAMHSA Special Incentive Grant to the Office of Substance Abuse, which includes the hiring of an epidemiologist to assess the magnitude and extent of the problem, and analyze the data. This new person will connect with our Divisions of Family Health and Community Health Epidemiology Team. 2) A Fetal Alcohol Spectrum Center for Excellence, whose first year will have an epidemiological focus. The grant, jointly led by the State Office of Substance Abuse and the Women's project in Portland designates our group to function as advisory to the project. 3) The successful March of Dimes MCH Grant to start up Maternal and Infant Mortality and Resiliency Review for Maine provides a natural link to perinatal addiction prevention and treatment.

In response to requests for guidance in identification and management of neonatal abstinence syndrome, the Perinatal Outreach staff convened regional meetings and various educational programs for health care providers across the state. Several partners were included in these sessions, including individuals from the Office of Substance Abuse, Treatment centers and law enforcement.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9.5	11	11.5	11	11
Annual Indicator	11.7	12.3	10.4	10.1	
Numerator	52	55	47	46	
Denominator	445061	446765	452554	457310	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	9.9	9.8	9.7	9.6

Notes - 2002

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

The latest indicator of 12.1, reported in the column for 2001, represents a five year average for 1997-2001. Due to the small number of youth suicide deaths in Maine each year, we have used five year averages since 1998. The national rate for teen suicides for 2000 was 8.2 deaths per 100,000 youths aged 15 through 19. Maine's five-year averages reported in 2000 and 2001 of 11.7 and 12.1 are significantly higher and point to one of the few measures in which Maine does not fare as well as the nation as a whole.

(Note: The denominator for the 2002 indicator was revised at the time the FY06 block grant application was submitted, due to changes in population estimates made by the Office of Data, Research and Vital Statistics, Maine Bureau of Health; the value for the indicator remains the same as originally reported.)

Notes - 2003

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

The 2003 indicator is the 5-year average for 1999-2003. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Notes - 2004

2004 data are not yet available.

a. Last Year's Accomplishments

Through the Maine Youth Action Network (MYAN), youth from several Maine high schools were involved in various aspects of youth suicide prevention during FY04. Notable accomplishments included several youth presentations on suicide prevention and bullying prevention in three schools.

The Office of Substance Abuse Prevention Information Resource Center received 223 requests for information about Suicide Prevention. They also received 9 calls from people concerned about suicide with a family member or themselves. Callers were referred to the crisis system for assistance.

The Maine Youth Suicide Prevention Program (MYSPP) web site experienced 7,043 visits, an average of 587 per month. The online Gatekeeper Training Resource Guide was accessed 6,550 times.

Resource Materials distribution included 4,469 Informational Booklets, 2000 Teen produced wallet cards, 100 teen produced posters and book covers and 5,148 Teen Yellow Pages. The MYSPP School Guidelines for Suicide Prevention, Intervention and Postvention were downloaded from the website 2,295 times. About 100 print copies were also distributed. A total of over 11,000 print materials were distributed in FY04.

A notable accomplishment was a Bureau of Health (BOH) led study of youth suicide in one area of the state. In response to a request from a community coalition to address a possible suicide cluster, MYSPP staff received assistance from a team of BOH and Centers for Disease Control and Prevention epidemiologists in the fall of 2004. Working with a community coalition, 11 focus groups and 20 individual interviews were conducted with local youth and adults to supplement the collection and analysis of fatal and non-fatal quantitative data.

The MIPP health educator participated in a cable access program with a local police department, and parents of a 15 year old shooting victim to discuss the contents and production of the MIPP produced Kids and Guns: Making the Right Choice video. The program was aired several times over the course of one month on local cable television.

Youth suicide prevention materials were consistently displayed and distributed at health fairs, conferences and workshops, as well as distributed upon request to schools and mental health clinicians.

All MYSPP training program materials for Gatekeeper Training, Training of Trainers, and Lifelines were updated and a transition was made from use of overheads to power point presentations. A new 2004-05 training brochure was created with a description of all MYSPP

training programs and, for the first time, online registration for programs was made available.

A total of 57 training programs were offered in 2004 to 1,771 participants:
- 16 Gatekeeper trainings attended by 375 participants,
- 7 Training the Trainer programs attended by 86 participants,
- 2 Lifelines Teacher training sessions attended by 25 participants,
- 3 Youth training sessions attended by 108 participants,
- 29 Awareness Education programs attended by 1,177

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide statewide access to crisis assistance and suicide prevention information	X			
2. Provide training and education programs statewide		X		
3. Provide guidance and technical assistance to school and community personnel for suicide prevention and intervention			X	X
4. Evaluate effectiveness of MYSPP training and education programs				X
5. Conduct surveillance of, analyze, and disseminate a report on youth self-inflicted injuries and suicide				X
6. Continue implementation of CDC funded Intervention Project		X		
7.				
8.				
9.				
10.				

b. Current Activities

Planning began for an advanced level training conference geared to individuals who attended basic suicide prevention gatekeeper training. A one-day conference was held in Portland in April 2005.

In conjunction with the Maine Chapter of the American Foundation for Suicide Prevention (AFSP Maine), the MYSPP supported, in November of 2004, a conference for suicide survivors and professionals who work with survivors. The conference was well received by the more than 100 individuals in attendance. In addition, the MYSPP and AFSP Maine co-sponsored a training program for a small group of suicide survivors to learn how to effectively tell the stories of their loss. The AFSP Maine Speakers Bureau will become an integral part of suicide prevention messages and survivor support activities in 2005. The impact on suicide survivors of participating in suicide prevention efforts is being measured through a contract with the Baton Rouge Crisis Intervention Center, and the University of Indiana at South Bend.

Development of a report containing epidemiological analysis and recommendations for community action on the community study of youth suicide is pending.

The MYSPP was directed through an Executive Order from the Governor to revise the program plan to strengthen the impact of the program in reducing youth suicide. Several new committees were formed to revise the program plan.

The MIPP health educator is providing leadership in bringing together individuals from various

agencies and expertise to develop recommendations related to restriction of access to lethal means. Other MYSPP committees include data, public awareness, school and community based suicide prevention and clinical and professional intervention.

c. Plan for the Coming Year

Continue implementation of the CDC funded School/Community Based Youth Suicide Prevention Intervention in 12 high schools.

Continue to provide Suicide Prevention Awareness Education, Gatekeeper Training Sessions, Lifelines teacher training, youth training and Reconnecting Youth Training to schools and communities statewide.

Continue to provide printed and electronic informational materials statewide on request.

Continue to promote the 24-hour crisis hotline to callers statewide through distribution of materials, the program website, and all education and training sessions.

Continue to provide technical assistance to communities and schools.

Continue to monitor suicide and self inflicted injuries among Maine youth statewide and issue a report on fatal and non-fatal youth suicide.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	82.5	80	80.5
Annual Indicator	82.8	81.7	80.1	80.7	80.8
Numerator	607	598	609	638	636
Denominator	733	732	760	791	787
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	81	81.5	81.5	82

Notes - 2002

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Reporting for 2001 is based on a five year average for 1997-2001. Percents reported for

previous years are also based on 5 year averages. No observable trend noted over 1997-2001. We don't expect to see much change through 2007 as the regional perinatal system is stable at this time.

Notes - 2003

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2003 indicator is the 5-year average for 1999-2003. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Notes - 2004

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2004 indicator is the 5-year average for 2000-2004. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

a. Last Year's Accomplishments

The Perinatal Outreach Program provided education and consultation to providers statewide. Capacity to provide education increased significantly during FY03 with the addition of a second nurse educator. 125 programs were presented and reached 1,144 health care professionals. Attendees were predominantly Registered Nurses, although many advanced practice nurses, nurse practitioners, physicians assistants, nurse midwives and home birth midwives, as well as, physicians benefited from these educational offerings. The topics of greatest interest related to reducing infant mortality and morbidity and reducing neonatal/childhood illness.

The Maine Birth Defects Program (BDP) implemented reporting of selected birth defects in May 2003. The BDP worked closely with the Children with Special Health Needs (CSHN) Program to assure access to services. All infants with conditions served by CSHN were referred and enrolled.

/2006/ The Perinatal Outreach Program contributed to the quality of perinatal care in Maine through the provision of 82 programs reaching 1,363 health care professionals during FY04. Attendees were primarily registered nurses, although many physicians, advanced practice nurses, nurse practitioners, nurse midwives and home birth midwives participated in the educational programs. Topics of greatest interest included basic and advanced fetal monitoring, neonatal stabilization and resuscitation and topics focused on reducing infant mortality and morbidity and reducing illness. The Perinatal Outreach Program also participated in the National Perinatal and Pediatric Outreach Conference in July 2004 with a poster presentation on Folic Acid Education in Maine. //2006//

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide education to perinatal care providers regarding high risk care				X
2. Continue to assure statewide access to perinatal and neonatal transport systems	X	X		

3. Continue data collection, abstraction, and review of medical records for Birth Defects Program				X
4. Collaborate with interested partners to maximize efforts related to birth defects surveillance				X
5. Partner in the Prematurity Prevention Campaign led by the MOD			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2006/ Maine submitted a competitive application to the Center for Disease Control and Prevention (CDC) for continued funding of the Maine Birth Defects Program for 2005-2008. The application was approved but not funded. With six years of planning and development, Maine is anxious to continue these efforts.

A review of reported cases included those with gastroschesis, neural tube defects and cardiac defects. Approximately 75% of all confirmed cases were referred to CSHN. Cases not referred include infant deaths and prenatally diagnosed cases that have not delivered. Preliminary analysis of reporting source revealed that 48% of cases were reported by hospitals and providers, 42% were identified through hospital discharge lists of medical records departments, with the remaining 10% reported by other sources such as hospital logs and the CSHN Program. //2006//

Maine has 2 Level III nurseries, Eastern Maine Medical Center in Bangor and Maine Medical Center in Portland, and 1 Level II nursery, Central Maine Medical Center in Lewiston. Recent staffing changes at the Level II nursery in Lewiston resulted in Central Maine Medical Center no longer being able to care for infants at less than 32 weeks gestation. This change means an additional impact on the Level III nursery in Portland. In addition, the Level III nursery in Bangor serving the state's northern population was significantly impacted with the loss of several neonatal Nurse Practitioners, as well as, their Perinatologist who was called to active duty.

/2006/ Staffing at Eastern Maine Medical Center, Level III Nursery in Bangor is gradually recovering from staffing changes through recruitment of nurses and neonatal Nurse Practitioners. An experienced Neonatologist is expected to join the staff in July 2005. The Central Maine Medical Center in Lewiston continues to limit its scope to pregnant women and neonates beyond 32 weeks gestation.

The Division of Family Health anticipates continued success of the collaboration with the Perinatal Outreach Education and Consultation Program. An additional Outreach Education Nurse, Kelly Bowden, NNP, increases capacity to provide education to health care providers across Maine through Lunch and Learn Programs related to the prevention of birth defects with folic acid and other preconception activities. The grant, supporting Perinatal Outreach, will be awarded through a competitive process during summer 2005. The successful applicant will provide education and consultation and assume a leadership role in a variety of public health activities, including participation in the establishment of the Maternal and Infant Mortality Review process. //2006//

c. Plan for the Coming Year

In September 2004, Title V submitted a successful proposal to the Maine March of Dimes for a $25,000 grant to start up a Maternal and Infant Mortality and Resiliency Review Program

(MIMRR) for Maine. The overall goal of the program is to strengthen community and state resources and a wide array of systems and policies for women, infants, and families. The goal of MIMRR, modeled after the National FIMR Program, is to learn how to prevent maternal, fetal, and infant deaths by considering the broad environmental, social, and economic context in which those deaths occur. In the spirit of humane systems for MCH in Maine, the review process seeks not to assign blame for individual deaths but rather to identify system-level gaps that we can address to create healthier and more nurturing environments for all babies in Maine. It also seeks to identify the resiliency factors that enable families to do well within the context of often severe stress. We view MIMRR as an ongoing "cycle of improvement," where subsequent case reviews provide feedback on the effects of previous strategies. To enhance and complement the case review process, we will incorporate a resiliency component in all phases of the program.

During the first six months of the March of Dimes grant (January -- June 2005), we 1) Established a network of about 100 people from a wide array of public and private, state and local organizations and from all walks of life who are committed to make this program a reality for Maine; 2) Formed four action teams: Technical Review, Community Action, Resiliency, and Steering Group; 3) Identified a Program Coordinator; 4) Advocated and testified for legislation (LD 1420) to provide statutory authority for the review panel; 5) Established direct links to the Maine Child Death and Serious Injury Review Panel to ensure that we work in synch with each other, and to the Maine Task Force on Early Childhood of the Governor's Children's Cabinet to ensure a mechanism for the translation of our work into policy and system change; and 6) Set into motion a process that includes family and community involvement from start to finish, honors all cultures, uses simple and non-jargon language, gathers and analyzes accurate and useful data, and respects families for their resiliency.

The Maine Birth Defects Program will refine program methodology with a goal to continue to collect and analyze accurate clinical information on several major birth defects. The program will expand on collaborative efforts with interested partners to maximize efforts and identify human, financial and technical resources.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	90	90	88	88	89
Annual Indicator	88.1	87.7	87.7	87.2	88.1
Numerator	11973	12056	11880	12070	12276
Denominator	13590	13750	13549	13846	13929
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	89	90	90	90	90

Notes - 2002

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (Risk Factor)

The indicator of 87.7 % is for the calendar year 2001. No observable trend noted. Maine fares better than the nation as a whole on this measure. In 2001, 83.4% of U. S. pregnant women received prenatal care beginning in the first trimester. The objective for 2007 of 90 % is the same as the HealthyMaine2010 objective for 2010.

The denominator refers to all Maine resident births, including those that occurred outside of Maine. This is the standard definition of live births used by Vital Records.

Notes - 2003

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

The performance objective for 2006 and beyond is 90%, which is the Healthy Maine 2010 goal.

a. Last Year's Accomplishments

During the CY04 Public Health Nursing (PHN) provided 18,261 home visits to individual clients, an increase of 18% from CY03. PHN attributes this to staff proficiency with electronic documentation resulting in increased productivity. Home visits by case type are illustrated in the attached Table 1 and Chart 1. The MCH population continued to receive in excess of 60 % of PHN service time.

Case types were categorized to allow for improved data capture preventing a comparison to CY03.

PHN continued to increase the number of MCH home visits to individual clients for the last four years. During this period well child clinics and participation in developmental clinic activities were reduced to allow for an increase in home visits to individuals with identified health needs. Over the four years the percentage of MCH visits to total visits were 68.6% for CY01, 68.8% CY02, 60.8% CY03 and 60.3% for CY04. Children 0-17 received the largest percentage of visits from PHN at 28% followed by TB at 21%. Other large categories were: parenting at 16%, postpartum at 14%, and refugee health at 9%.

Due to both the geography of the state, and the limited PHN staff, the Women and Children's Preventive Health Services Program (WCPHS) funds three (3) Community Health Nursing agencies to provide home health nursing services to mothers and children in portions of central and southern Maine.

During SFY04 Community Health Nursing (CHN) provided 872 prenatal visits to 229 women, 4143 postpartum/parenting visits to 1536 mothers/parents, 5696 visits to 2131 infants and children, 682 visits to 147 children with special health needs, and visits to 24 children with elevated lead levels.

A standard language for nursing practice is required to meet the needs of the profession, the clients, and nursing, to describe and evaluate its impact on patient outcomes, and to generate reliable, useful and valid data. PHN has adopted the research based Omaha Classification System (OCS) consisting of nursing diagnosis/client problems, interventions and client outcomes to document its client care in Carefacts

Use of OCS facilitates tracking client trends and progress, billing, reporting to external accreditors, management decision-making, assessing staffing and scheduling needs, and fosters the inclusion of nursing information into national data sets. Our electronic documentation is able to produce data that describes client outcomes. Their knowledge, behavior and status are measured upon admission and discharge. Three nursing diagnoses tracked were Income, Ante/Postpartum and Growth and Development.

/2006/ Clients continue to demonstrate progress related to their knowledge, behavior and status relative to a nursing diagnosis of AntePartum/PostPartum. PHN is pleased to see that nursing interventions by its staff appear to be producing positive outcomes for its clients. //2006//

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to monitor incorporation of teen parents as a priority population in the Home Visitation Program		X		X
2. Continue collaboration with the HFP with reciprocal referral, PHN/CHN identifying health needs, HF identifying non-nursing supportive services	X			X
3. Provide TA to providers of parent education & support services related to implementation & maintenance of parent education & support services				X
4. Develop a transition plan for moving home visitation to the Division of Early Childhood in the new Office of Child and Family Services				X
5. Provide financial support for incorporating a uniform prenatal curriculum for home visiting programs				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the initial assessment of each client by public health nursing, an assets checklist is completed to establish a baseline and to assist the Public Health Nurse in development of an individualized plan of care for the client.

In 2004 only primary clients received the Asset Checklist for completion. Data parallels that of 2003 demonstrating child care, immunization status, dental care and accessing services as assets requiring strengthening. (Figure 1 attached)

/2006/ During FY05, the new Department of Health and Human Services (DHHS) planned the second stage of its reorganization determining where all the boxes from the prior organizational charts of the former Departments of Human Services and Behavioral and Developmental Services are to be located in the new organizational structure. The purpose of moving programs or specialty areas is to support the achievement of the DHHS vision. Two MCH programs will move out of the Bureau of Health (BOH) into a new Division of Early Childhood in the Office of Child and Family Services (DEC/OCFS). The two programs are Home Visitation and the Early Childhood Initiative. Transition planning will occur early in FY06 with an anticipated completion in early FY07.

In FY04, 31% of the families enrolled in the Home Visiting Program (Healthy Families, Parents as Teachers, and Parents Are Teachers Too) enrolled in the program in the prenatal period. Comparison of outcomes for families enrolled before the birth of a child and families enrolled after the birth showed higher percentages of breastfeeding and higher percentages of mothers receiving optimal care during their pregnancy in families enrolled prenatally. These differences were statistically significant. //2006//

c. Plan for the Coming Year

The Public Health and Community Health Nurses will continue to conduct home visits for pregnant women, mothers and children to support a healthy pregnancy and/or support their transition to parenting.

The Healthy Families Program will continue to provide technical assistance and support to agencies implementing these programs.

/2006/ Public Health Nursing will continue, through CareFacts, to monitor documentation and analysis of data and use the data to inform practice and priorities. This information will be utilized in our QI process for continued improvement in services offered by PHN.

Continue working with evaluation of the home visitation program, Healthy Families, by conducting a thorough analysis of FY04 data and implementing appropriate standards of data documentation in an effort to assure accurate, clean data.

The need to develop a central referral process was identified both by Public Health Nursing staff and clients. In the satisfaction surveys clients, indicated the need for a more timely response to their request for nursing services. Data indicated the amount of time spent by each of our public health nursing staff, in responding to referrals, decreased the amount of time spent in providing services to our clients. We conducted a literature search and invited an expert from the largest homecare agency in Maine to present to management the development of Central Referral in their agency. In December 2004 the model for statewide Central Referral was presented to six offices and staff input regarding the application of this process was solicited.
Vision Statement : All clients have access to appropriate and timely health care resources.

Goals of Central Referral:

- A unified agency approach
- Identification of health needs of referrals
- Providing support for the staff

Deliverables:

- One contact site for statewide referrals
- More efficient processes, maximizing staff time for client care and case management.
- Single access point
- Skilled professional screening
- Consistent standardized approach to services focusing on client needs
- Determination and prioritization of client needs

PHN is also undergoing a reorganization of our regional offices in an effort to provide improved support and supervision for staff that will result in improved client services.

The Division of Family Health will work with the DEC of OCFS to develop a transition plan for management of the home visitation program. The Home Visiting Program will fund training for staff of all grantees to learn about the same prenatal curriculum for home visitors. //2006//

D. STATE PERFORMANCE MEASURES

State Performance Measure 2: *The percent of unintended births in women less than 24 years of age*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	53%	60%	59%	58%	57%
Annual Indicator	56.0	61.5	60.9	59.2	59.2
Numerator	2067	2272	2153		
Denominator	3693	3693	3533		
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	58	57	56	55	54

Notes - 2002

The percent of unintended births in women less than 24 years of age

The indicator of 50% is for the calendar year 2000. Because the indicator has not changed since 1996, we considered dropping it. However, upon further discussion, we decided to keep it because it is one of the few measures that gives us information about the often overlooked population of young adult women. To this end, next year we'll report the percent of unintended births according to age groups 18-19 and 20-24.

We rely on the CDC to provide us with data for this measure. To date, no data is available for 2001.

Notes - 2003

The percent of unintended births in women less than 24 years of age.

The data source for the 2003 indicator is the 2003 PRAMS survey (Maine data).

Notes - 2004

The percent of unintended births in women less than 24 years of age.

2004 data are not yet available. TVIS requires that an estimate be entered for 2004; we used the 2003 indicator as the 2004 estimate.

a. Last Year's Accomplishments

Twenty-nine family planning clinics across the state served 32,045 clients, including 25,551 teens and low-income women.

An antecedent for unintended pregnancy is a lack of aspirations. Meaningful youth involvement can increase these aspirations. The Maine Youth Action Network (MYAN), a program of the People's Regional Opportunity Program and the University of Southern Maine, Muskie School continues to grow. In FY04, we renewed a joint contract funded by the Partnership for a Tobacco-free Maine, Maine Cardiovascular Health Program, Maine Youth Suicide Prevention Program and Teen and Young Adult Health Program. The leveraged funding continued to maximize resources and services provided to youth, while meeting the goals of multiple BOH Programs. Youth staff and other forms of youth input continue to inform our work with these projects. Technical assistance is provided to Youth Advocacy Groups of the Healthy Maine Partnerships, as well as, traditional peer leader groups the network has included. Other youth leadership groups were invited to participate in Network activities and both the Youth Leadership Action Team, a group of youth in care, and the CSHN youth council, Young Educators and Advocators of Maine (YEA ME) once again presented and participated in MYAN events. Youth and advisors attended 16 regional meetings where they gained knowledge and skills and participated in action planning for their local programs. The willingness of MYAN to travel to all corners of the state continues to be appreciated by our rural schools.

From 2001-2004, Maine received the Maternal and Child Health Bureau, Integrated Comprehensive Women's Health grant. This funding and project framework established five formal coordinating bodies to create and sustain a coordinated system of care for Maine women. These formal coordinating entities created and guided integrated, coordinated and enhanced systems for promoting comprehensive women's health concerns in a variety of settings with innovative, unique, efficient, and coordinated approaches to achieve the project's goals.

One of the coordinating entities, the Health Services Task Force (HSTF), created measures of performance across categorical BOH programs providing women's health care services. The core functions of the HSTF were the development and piloting of integrated, comprehensive women-centered models of health service delivery within the existing BOH Programs and the development of common performance measures across BOH contracts, which contributed to a streamlined process for contracting across publicly funded women's health services.

The Division of Family Health was strengthened internally by bringing together several categorical programs that contract with the same agency to identify ways to simplify the contracting process and start identifying the categorical barriers that block the purchase and delivery of more comprehensive services for women.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Clinical Services	X			
2. Community-based pregnancy prevention and family planning outreach		X	X	X
3. Continue to monitor via PRAMS			X	
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

The TYAHP collaborates with the Women's Health Consultant on girls health issues, facilitates a listserv for girls health issues and programs, and provides technical assistance in this area. The listserv supports a comprehensive approach to promoting girls healthy development, including sexuality issues. Resources available to address unintended pregnancy are shared on the listserv. An eating disorders work group identified priorities for the coming year including the close connection between body image and healthy sexuality. An interagency work group in young adult health (ages 18-24) was recently formed to identify better ways to serve post-high school young people.

The MYAN offered a fall conference in 2004 with Governor Baldacci as keynote speaker. MYAN expanded regional meetings to 8 regions in the state reducing travel time for youth groups. Continuing feedback from the programs involved in the network is used to refine services offered by the MYAN staff. In addition to topical training on various issues, training on youth-adult partnerships, and on advocacy was offered. Three statewide projects to include youth in planning, policy change, and advocacy continue, including the issues of tobacco, suicide prevention and bullying.

c. Plan for the Coming Year

During FY06 the TYAH Program plans to serve approximately 32,900 clients (anticipated FY05 level). Funding reductions and increased health care costs preclude any increase in services and will create a challenge for maintaining current levels of services.

In an effort to further promote the importance of collaboration, the TYAH staff will continue to play a lead role on the Eating Disorders Work Group, the Young Adult Health Workgroup, the Maine Interdepartmental Student Health Survey Committee, and the Strategies for Healthy Youth Workgroup. Staff also serve on the following committees: the Kids Count Committee, the Suicide Prevention Steering Committee, the School Health Advisory Council, the Healthy Maine Partnerships Management Team, the Bureau's Evaluation Workgroup, the Physical Activity and Nutrition Workgroup, and the Preventive Women's Health Workgroup.

The Maine Youth Action Network will continue to offer training and technical assistance to youth leadership programs throughout the state. A November 2005 conference is planned, as well as, 2 regional trainings in 8 regions of the state. A website, biannual newsletter, and monthly email to participating programs will continue to be used to disseminate information, gather input, and involve youth in program planning. Youth will continue to be involved in statewide projects focused on tobacco use prevention, youth suicide prevention and others to be determined.

State Performance Measure 3: *Percent of women enrolled in WIC that are breastfeeding their infants at six months of age.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	30%	26%	24%	23	24
Annual Indicator	23.7	23.2	21.6	22.4	24.6
Numerator	213	255	209	212	
Denominator	898	1101	967	947	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	26	27	28	29

Notes - 2002

Percent of women enrolled in WIC who are breast feeding their infants at six months of age. (Capacity)

Data for this performance measure is obtained through the state WIC Program. Data for 2002 comes from a random sample of WIC mothers conducted from November to December of 2002. The proportion of women still breastfeeding at 6 months decreased on average 3.1% (95% c.i. 1.3-7.3) per year from 1997-2001. This highlights the importance of continuing this measure and focusing on efforts to reverse the trend. For more information, see the Narrative. Also, knowing that values and behaviortal changes take time, we have adjusted our long-range objectives.

Notes - 2003

Percent of women enrolled in WIC who are breast feeding their infants at six months of age. (Capacity)

Data for this performance measure is obtained through the state WIC Program. Data for 2003 is based on a two month sample of WIC mothers conducted from November to December of 2003. It is dificult to assess the significance of slight variations from year to year.

Notes - 2004

Percent of women enrolled in WIC that are breastfeeding their infants at six months of age.

2004 data are not yet available. TVIS requires that an estimate be entered for 2004; we use 2003 data from PedNSS as the 2004 estimate. The PedNSS figure is based on infants enrolled in WIC who turned 6 months of age during the reporting period by/on their date of visit. We are switching to PedNSS data because we realized that the way we had been calculating this measure in past years was not valid. For the 2003 and earlier indicators were based on a 1-2 month sample, with the numerator being the number of infants in WIC who were breastfed at least 6 months; the denominator was the number of infants in WIC who were breastfed at least 6 months plus the number of postpartum teens and women who were not breastfeeding. The measure was not valid, as calculated, because the infants of these nonbreastfeeding postpartum teens/women were less than 6 months of age.

a. Last Year's Accomplishments

In preparation for the production of a poster promoting breastfeeding and working, the WIC Program contracted with a photographer to photograph women who worked and breastfed their babies. Of the 16 women, one worked in manufacturing, one in a coffee shop (Dunkin Donut)

and the other in a restaurant (Friendly's).
/2006/ The poster has been designed and printing bids solicited. We anticipate the poster to be ready for distribution in FY06. //2006//

In June 2003, three WIC and 1 Public Health Nurse completed the Certified Lactation Counseling (CLC) training. WIC encourages staff who have completed the CLC training to undertake steps to become Board Certified Lactation Consultants.
/2006/ Since the Initiatives inception in 1999, 57 WIC staff and 7 PHNs have completed the CLC training. During FY04, two WIC staff were trained and 21 WIC, 1 PHN and 2 Healthy Families staff were trained in FY05. Staff reported being more comfortable discussing breastfeeding with clients after taking the training. More breastfeeding classes and support groups are being offered and two staff members have successfully tested for the International Board Certified Lactation Consultant (IBCLC) certification. //2006//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor implementation of WIC performance measure specific to BF				X
2. Provide technical assistance to local WIC agencies to increase breastfeeding rates and duration				X
3. Continue implementation of Loving Support Campaign		X		X
4. Continue developing Certified Lactation Counselors within WIC, PHN and CHN		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Consistent with the goals and objectives of the Food and Nutrition Services Strategic Plan, one of the performance measures is to increase the rate of breastfeeding among WIC participants.

/2006/ "Breastfeed: Give the Gift of a Lifetime" a book that promotes breastfeeding continues to be distributed to businesses such as accountants, law firms, chiropractors and beauty salons to place in their waiting rooms.

The WIC Program sponsored Marsha Walker as a speaker on breastfeeding topics for the Association of Women's Health and Neonatal Nurses. WIC also sponsored guest speaker, Amy Spangler at the Annual Breastfeeding Conference on May 20, 2005. Her topics included; Breastfeeding and the Media: Part of the Problem or Part of the Solution; Breastfeeding Education: Mastering the Art of Teaching Without Preaching; and Breastfeeding and the Working Mother. Amanda Sears from the Environmental Health Strategy Center also presented on Environmental Contaminants as They Relate to Breastfeeding.//2006//

c. Plan for the Coming Year

/2006/ Continue to work collaboratively with WIC Program to encourage client acceptance of PHN home visitation services.

Continue training of Child Care Centers on supporting breastfeeding mothers. To support breastfeeding friendly environments, childcare centers provide space for mothers to breastfeed their babies, have no images of baby bottles, have plans to train new staff on supporting breastfeeding mothers, and have policies consistent with supporting breastfeeding babies.

Distribute posters from photos, of working mother's breastfeeding, taken in FY03 with the phrase "What do all these mothers have in common? They all worked and breastfed their babies and so can you."

Technical assistance will include sharing with local agencies, activities from other local agencies as well as from states that have improved breastfeeding rates and duration. //2006//

State Performance Measure 4: *The percentage of adolescents who have received routine dental care in the last year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	78%	78%	80%	80%
Annual Indicator	79.6	78.6	78.6	80.2	80.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	81	82	82	83

Notes - 2002

The percentage of adolescents who have received routine dental care in the last year (Capacity)

The source of data is the Youth Risk Behavioral Survey (YRBS) which reports on the percentage of junior and high school students who have seen a dentist for a check-up, exam, cleaning, or other dental work within the 12 months proceeding the survey. The YRBS is conducted every other year during the odd numbered year (ex: 1999, 2001). Hence, indicator/objectives will mirror odd number years in even years.

Notes - 2003

The percentage of adolescents (high school students) who have received routine dental care in the last year (Capacity)

The source of data is the Youth Risk Behavioral Survey (YRBS) which reports on the percentage of middle and high school students who have seen a dentist for a check-up, exam, cleaning, or other dental work within the 12 months proceeding the survey. The YRBS is conducted every other year during the odd numbered year (1999, 2001, 2003, etc.). Hence, indicators and objectives in even numbered years will mirror those for odd numbered years.

(Note: The 2003 indicator was revised at the time of the FY06 block grant application to include one decimal place; the previously-reported indicator was 80.)

Notes - 2004

The percentage of adolescents (high school students) who have received routine dental care in the last year (Capacity)

The data source for this indicator is the Youth Risk Behavior Surveillance System (YRBS) which reports on the percentage of high school students who have seen a dentist for a check-up, exam, cleaning, or other dental work within the 12 months prior to the survey. The YRBS is conducted every other year during odd numbered year (1999, 2001, 2003, etc.). Hence, the 2004 indicator is taken from the 2003 administration of the survey.

a. Last Year's Accomplishments

Continued support of community agencies and community health centers providing preventive and restorative oral health services, through the Dental Services Development and Subsidy Programs funded by the Fund for a Healthy Maine, Maine's tobacco settlement, has helped to sustain Maine's limited oral health infrastructure.

/2006/ The OHP staff hygienist, Kristine Perkins, participated in a workgroup to develop a Coaches Manual with a focus on Tobacco Free Athletes. She presented information on the oral health implications of smokeless tobacco use, and as of June 2003, a draft of this manual was prepared. Ms. Perkins presented two poster presentations at the 2003 National Oral Health Conference: "Evaluating, Maintaining and Improving a School Oral Health Program" and "Establishing a Database and Electronic Reporting System for a School-based Sealant Program." In collaboration with the Department of Education (DOE) staff, she also developed a set of Oral Health "Key Concepts" to become a part of the health education component of the Coordinated School Health Program Curriculum Guidelines. She served as a Team Leader for the ASTDD School and Adolescent School Health Committee, and joined the New Hampshire Sealant Task Force as a consultant. //2006//

Inclusion of a Youth Risk Behavior Survey (YRBS) question on the frequency of receiving dental care was retained. At this time, this is the only source for statewide data related to the adolescent population.

Consultation and technical assistance was provided as requested, for educators, health and social services providers, related to the oral health needs of this population group.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support for community-based capacity building resulted in increased infrastructure	X			X

2. Continue with YRBS and middle school dental care question			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2006/ A new activity in which the OHP has some involvement is an expansion of school-based sealant programs to include middle school students. The OHP serves as a conduit for funding received by Oral Health America, a Chicago-based private non-profit organization, from Ronald McDonald House Charities, and other funders, as part of its "Smiles Across America" Initiative. Funding will go to community agencies in Washington County and the City of Portland that work with school-based health centers, so that the sealant program can be integrated into those centers and to enhance sustainability since the centers can bill insurers. We estimate that about 600 young adolescents may receive dental sealants through this funding. //2006//

c. Plan for the Coming Year

/2006/ This performance measure will be eliminated in FY06 as the Healthy People 2010 objective was achieved.

The OHP will participate on the YRBS Planning Team. OHP will continue its support of capacity building for oral health in community programs, and continue to collaborate with other interested parties about oral health and School-based Health Centers. //2006//

State Performance Measure 5: *The motor vehicle death rate per 100,000 among children 15 to 21 years of age*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	27	28	27	27	26
Annual Indicator	29.5	29.7	31.2	28.7	28.7
Numerator	177	178	191	178	
Denominator	600053	600140	611271	620921	
Is the Data Provisional or Final?				Provisional	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	28	27	26	25	24

Notes - 2002

The motor vehicle death rate per 100,000 among persons 15-21 years of age (outcome).

Beginning in 1998, the rate reported is a 5 year average due to the small number of motor vehicle deaths in this age group each year. The indicator for 1998, for example, is the average for the 5 year period of 1994-1998.

The 2002 indicator was updated at the time of the FY06 block grant application due to revision of the population estimate (used in the denominator) by the Office of Data, Research and Vital Statistics, Maine Bureau of Health. The previously-reported value for 2002 was 31.3. The revised 2002 indicator for 15-19 year olds was 30.3; for 20-21 year olds, the revised indicator was 34.0. (The previously-reported indicators for these age groups were 30.4 and 33.7, respectively.)

Notes - 2003

The motor vehicle death rate per 100,000 among persons 15-21 years of age.

The 2003 indicator is the 5-year average for 1999-2003. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

For 1999-2003, the average annual rate was 28.4 per 100,000 for 15-19 year olds and 29.3 per 100,000 for the 20-21 year olds.

Notes - 2004

The motor vehicle death rate per 100,000 among children 15 to 21 years of age.

2004 data are not yet available. TVIS requires that an estimate be entered for 2004; we used the 2003 indicator (which is the average annual rate for 1999-2003) as the 2004 estimate.

a. Last Year's Accomplishments

/2006/ The Traffic Safety Educator was elected chairperson of the Maine Transportation Safety Coalition (MTSC) and has been very involved in planning and implementing transportation safety activities in the state during FY04. //2006//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop resource materials on young driver safety		X		X
2. Work with MCH Epidemiologist to conduct more detailed analysis of 15-21 year old motor vehicle death rates				X
3. Monitor impact of booster seat legislation				X
4. Work with MCH Epidemiologist to better understand factors contributing to Maine's apparent higher child (1-14 year old) motor vehicle death rate				X
5. Work with CODES to develop a fact sheet on booster seats				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2006/ The TSE is very involved in the Northeast Transportation Safety Conference scheduled for April 2005 in Portland Maine. She will be leading a breakout session related to CPS issues. //2006//

c. Plan for the Coming Year

During FY06, MIPP staff will continue to:

1. Provide training and information to advocates on safe driving and the importance of buckling up
2. Provide technical assistance to legislators, organizations, and other professional advocates on a standard safety belt law for all ages in Maine
3. Continue to collaborate and coordinate activities with the MTSC in promoting child passenger, bicycle, and pedestrian safety issues, including the Safe Communities concept.
4. MIPP in collaboration with the MTSC will continue to identify and recognize local efforts through the Community Transportation Safety Award.
5. The program will develop and maintain a Web site for dissemination of prevention information that includes prevention resource contacts, data, training opportunities, and links to other Maine and national injury prevention resources.
6. MIPP will continue to collaborate and coordinate on occupant protection safety issues with the Maine Transportation Safety Coalition as well as other committees, and state agencies involved in protecting the safety of Maine's young drivers.
7. Data provided through all MIPP Fact Sheets will be kept current and distributed upon request.
8. Provide two 4-day child passenger safety technician, and one, one-day child passenger safety technician re-certification class.
9. Convene site managers once yearly to celebrate their accomplishments and provide program and car seat updates.
10. Continue designation as Maine NHTSA coordinator for child passenger safety and maintain child passenger safety technician list for state.

State Performance Measure 7: *To assure timely access to genetics services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90%	90%	92%	93	
Annual Indicator	89.9	87	86.3	86.5	

Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

To assure timely access to genetics services

The most recent indicator of 87 % is for State Fiscal Year 2001. This indicator has been measured by calculating the % of pregnant women receiving genetic services who are seen within two weeks of referral.

As of FY2004, this SPM will be changed (see SPM 12 and narrative for further details). The 92% objective for FY 2002 and the 93% objective for FY 2003 pertain to the original SPM 7.

Notes - 2003

To assure timely access to genetic services.

The most recent indicator of 86.5% is for State Fiscal Year 2003. This indicator has been measured by calculating the % of pregnant women receiving genetic services who are seen within two weeks of referral.

2003 is the last year that data will be reported on this measure. Planning will begin in the fall of 2004 for the new state measure #12, which will measure the % of primary care providers who have knowledge of the impact of genetics on the health of children.

Notes - 2004

To assure timely access to genetics services.

This state performance measure has been phased out.

a. Last Year's Accomplishments

/2006/ During FY04 728 individuals and their families benefited from comprehensive genetic services at grantee agencies. These included in-patient referrals, high-risk clinic collaborations, specialty clinic consultations, telemedicine and traditional genetic clinic services. Agencies are no longer collecting information on timeliness of services as this measure was discontinued.

During FY04, Maine genetics providers conducted 91 presentations on various topics. Educational programs reached 541 professionals, students and members of the public. Changes at genetics agencies allowing less time available for outreach education resulted in fewer educational programs than in past years. //2006//

Reporting of selected birth defects began occurring May 1, 2003. All birth hospitals identified two contacts to work closely with the MBDP, one within the nursery and one from medical records. Abstraction of records is underway to collect clinical data on each case. The Nurse Coordinator works closely with CSHN staff to ensure referrals are made.
/2006/ Hospitals, specialty and primary care providers, and CSHN Program submitted case reports. Cases were also identified using hospital medical records discharge lists with ICD-9 codes. Electronic birth certificate information was also used but is not a

major source of cases.

Two medical center genetic programs, Eastern Maine Medical Center and Maine Medical Center received, by competitive bid, state grants to support comprehensive genetic services. Together these centers will serve a larger client base with a broader focus that includes cancer genetics and public health genetics. //2006//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish and implement core performance measures and collaborative activities across grantee agencies				X
2. Collect and analyze data measuring access and healthy outcomes following genetic service delivery				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Genetics Program Advisory Committee comprised of genetics professionals, consumers, nurses, BOH staff (including the MCH Medical Director), and the CSHN Program Manager continued to consult with the Program regarding provision of comprehensive genetic services in Maine.

/2006/ The competitive process to award grant funds to support genetic services is completed and will increase access to state supported genetic services, outreach and education, and quality of services. As a result of the RFP process, $400,000 in state funds were awarded to two qualified genetic centers. Representatives from both centers will collaborate in the spring and summer of 2005 to establish core performance measures and reporting formats related to these grant activities. The collaborative discussions related to performance measures will provide the content for a logic model related to genetic services in Maine. The logic model will be used to guide programmatic decision-making and measure progress toward improved outcomes. //2006//

c. Plan for the Coming Year

State Performance Measure # 7 will be eliminated in FY06. During the course of survey planning activities for FY06 and beyond, the Genetics Program determined that the population surveyed would differ from year to year, thus making meaningful progress or comparisons impossible. While this performance measure will no longer be monitored, the survey and information obtained are important for continued improvement of the integration of specialty and primary care services.

The Genetics Program will explore establishing a new partnership with The Genetics Division

of The Foundation for Blood Research. This partnership will facilitate the development of a survey tool to assess health care provider knowledge and awareness of the impact of genetics on the health of their patient population. Another area of potential partnership involves an assessment of barriers and opportunities for further use of tele-medicine in Maine to improve access to genetic services.

Together with the two funded agencies, the program will continue to assess access to genetic services and improved health outcomes through more standardized data collection.

State Performance Measure 8: *The percent of overweight adolescents in Maine*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14.0	14%	14	10	13
Annual Indicator	13.0	10.3	10.3	13	12.8
Numerator	18861				
Denominator	145087				
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	12	11	11	11

Notes - 2002

The percent of overweight adolescents in Maine

Beginning with calendar year 2001, the data we report is based on the YRBS overweight high school students. Overweight defined as >=95% BMI% for age. The YRBS is done every odd year, so the 2002 indicator is an estimate that reflects the result of the YRBS 2001 survey. The indicator for 2001 (10.3%) is based on a weighted sample from the YRBS, so no numerator and denominator are available. The sample is based on grade levels 9-12, not on any specific age range. Prior to 2001, the performance measure was based on the National Health and Examination Survey (NHANES III).

Notes - 2003

The percent of overweight adolescents in Maine

Beginning with calendar year 2001, the data we report is based on the YRBS overweight high school students. Overweight defined as >=95% BMI% for age. The YRBS is done every odd year, so the 2003 indicator reflects the result of the YRBS 2003 survey. The indicator for 2003 (13%) is based on a weighted sample from the YRBS, so no numerator and denominator are available. The sample is based on grade levels 9-12, not on any specific age range. Prior to 2001, the performance measure was based on the National Health and Examination Survey

(NHANES III).

Notes - 2004

The percent of overweight adolescents in Maine.

Beginning with calendar year 2001, the data source for this indicator is the Youth Risk Behavior Surveillance System (YRBS), with "overweight" defined as >=95th percentile of BMI for age. The indicator is reported for high school students (grades 9-12). The YRBS is conducted every other year during odd numbered year (1999, 2001, 2003, etc.). Hence, the 2004 indicator is taken from the 2003 administration of the survey.

In 2003, this indicator was rounded to a whole number (i.e., 13%). We report the indicator to the first decimal place for 2004, hence the apparent "change" to 12.8.

Prior to 2001, the performance measure was based on the National Health and Examination Survey (NHANES III).

a. Last Year's Accomplishments

Maine data shows a high rate of overweight among its youth. Maine's 2003 Youth Risk Behavior Surveillance System indicates that 13% of high and middle school students were considered overweight and 15% of high and 18% of middle school were considered at-risk for overweight.

/2006/ The Bureau of Health (BOH) Physical Activity and Nutrition (PAN) Program has made significant progress in establishing a coordinated state infrastructure for the prevention of obesity and chronic diseases. The work of the program is supported by funds received from the Centers for Disease Control and Prevention since June 2003 to build capacity for physical activity and nutrition. Year 2 objectives of the PAN Program include continuing the state and local infrastructure development for obesity prevention and control, completing the Maine PAN Plan, implementing and evaluating a school soda/snack vending pilot intervention, developing strategies to implement community interventions, continuing to build capacity for surveillance system components, and progressing towards a performance evaluation system.

Several new components of the Healthy Weight Awareness Campaign were introduced during FY 04. Each phase was designed to present a simple aspect of improving nutrition and increasing physical activity. Components of the campaign included promoting local walking routes, portion sizes, indoor walking, and TV off and out of the bedroom. A combination of television, newspaper, and radio messages was used, along with posters and direct mail information packets. Focus groups were conducted with low-income and rural parents to explore prevailing attitudes and perceptions regarding diet and exercise. Participants indicated that busy lifestyles and scheduling conflicts often resulted in poor diet choices and a lack of time for individual exercise. Parents wanted more guidelines regarding appropriate portion size, felt too exhausted from the rigors of day-to-day living to be able to exercise in a formalized manner, were challenged by seasonal weather concerns and a perceived lack of low-cost winter recreational options, and the parents who were more proactive in providing proper nutrition and physical activity for their children were more attuned to the reported negative effects of excessive screen time. //2006//

Maine Nutrition Network (MNN) projects focused on children and adolescents during FY04 included training for elementary and middle school teachers as well as food service staff; nutrition education to preschool children, teen parents and families in Waldo county; provision of funds for teaching, demonstration supplies and educational nutrition field trips for elementary age children; nutrition and food preparation lessons to children participating in the National Youth Sports Program; and technical assistance and access to books with food and nutrition themes to town librarians from low-income areas.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with partners to achieve the Healthy People 2010 nutrition/physical activity and fitness objectives			X	X
2. Enhance Maine's nutrition and physical activity surveillance infrastructure				X
3. Improve the nutritional and physical activity status of Maine's MCH population	X		X	X
4. Continue monitoring via YRBS and the Maine Child Health Survey			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Nutrition Program continues to collaborate with the Bureau of Health's PAN Program to build Maine's infrastructure to address obesity prevention. The MCH Nutrition Program participates on the PAN Coordinating Council. The purpose of the PAN Coordinating Council is to communicate, coordinate, integrate, and leverage resources to promote optimal standards and practices in and across programs with physical activity and nutrition components. The MCH Nutrition program is also partnering with the PAN Program to finalize the Maine PAN Plan, as well as participating on the workgroup to implement the Plan.

/2006/ The MCH Nutrition Program is collaborating with the MNN and other colleagues on the development of an action packet with guidelines for creating environments that increase vegetable and fruit consumption. Other MCH Nutrition Program activities include participation on a newly established eating disorders workgroup, and partnering on the development of messages for the Healthy Weight Awareness Campaign regarding portion size and promoting consumption of fruits and vegetables. According to data from the Maine Health Information Center, 95 individuals in Maine were hospitalized in 2003 due to eating disorders, approximately 50% of whom had anorexia nervosa listed as the primary diagnosis. Just over 1,000 outpatient hospital visits, with eating disorders as the primary diagnosis, occurred in 2002. //2006//

c. Plan for the Coming Year

The MCH Nutrition Program will maintain its collaboration with the Physical Activity and Nutrition (PAN) Program in building Maine's infrastructure to prevent obesity and other chronic diseases.

/2006/ Initiatives for the PAN Program in FY06 will include continuing development of a coordinated state and local infrastructure for obesity prevention and control, completing the evaluation of the school soda/snack vending pilot intervention and expansion of a school/community intervention, providing resources and support for state and local partners to implement interventions in the PAN Plan, completing and disseminating a PAN surveillance plan, and progressing towards a performance evaluation

system. //2006//

The MCH Nutrition Program will continue its partnership with the MNN to plan and implement the projects of Maine's Food Stamp Nutrition Education Plan funded by the U.S. Department of Agriculture. Collaboration will also proceed with the MNN and Maine Cardiovascular Health Program on the implementation and ongoing development of the Healthy Weight Awareness Social Marketing Campaign.
/2006/ The MCH Nutrition Program will continue to partner with the eating disorders workgroup to reduce the number of people with eating disorders in Maine and to provide more effective treatment for individuals with eating disorders. //2006//

State Performance Measure 9: *The percent of kindergarteners who are overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				13	15
Annual Indicator			13	15.2	15.4
Numerator					209
Denominator					1358
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	14	14	13

Notes - 2002
The percent of children who are overweight

This is a new measure. For 2002, we used baseline data from the NHANES III. However, starting in 2003, we will be using the Maine Child Health Survey to determine this measure. The Survey, developed by our Maine Asthma Program in partnership with other programs in the Bureau of Health, is administered to children in kindergarten, as well as to fifth graders.

Notes - 2003
The percent of children who are overweight

This is a new measure. For 2002, we used baseline data from the NHANES III. However, starting in 2003, we use the Maine Child Health Survey to measure this indicator. The survey is administered to children in kindergarten, third, and fifth grades. Data is weighted to make it possible to generalize to the whole population. The indicator of 15.2 % (c.i. 10.5 - 21.9) is for Maine children who entered kindergarten in the fall of 2002.

Notes - 2004
The percent of kindergartners who are overweight.

2004 indicator: Source is the Maine Child Health Survey, conducted during the 2003-2004 school year. Data were not weighted due to a low response rate (17.6% for kindergarten and 3rd grade combined). A total of 1599 kindergartners participated in the survey; weight status was not obtained for 241 (15.1%) of these children. The results reported here are for the 1358 children for whom weight was known. Due to the low response rate and high percentage of missing weight statuses, the results should not be considered generalizable to all kindergartners in Maine.

2003 indicator: Source is the Maine Child Health Survey, conducted during the spring/summer 2002 kindergarten registration/screening (for children who would enter kindergarten in the fall of 2002). Data are weighted to allow analysts to obtain statewide estimates. The response rate for the survey was 40%.

2002 indicator: Baseline data from the NHANES III. However, starting in 2003, we use the Maine Child Health Survey to measure this indicator. The survey is administered to children in kindergarten, third, and fifth grades. The indicator of 15.2 % (c.i. 10.5 - 21.9) is for Maine children who entered kindergarten in the fall of 2002.

a. Last Year's Accomplishments

The strategies for SPM # 8 and # 9 overlap considerably. To reduce duplication, activities are not repeated.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with partners to achieve the Healthy People 2010 nutrition/physical activity and fitness objectives			X	X
2. Enhance Maine's nutrition and physical activity surveillance infrastructure				X
3. Improve the nutritional and physical activity status of Maine's MCH population	X		X	X
4. Continue monitoring via YRBS and the Maine Child Health Survey			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 10: *The percent of high school students who report being in a physical fight in the past year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			31	30	27
Annual Indicator		31	31	26.5	26.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	26	26	25	25	24

Notes - 2002
To reduce physical fighting among adolescents in Maine.

This is a new measure. The data source will be the biennial Youth Risk Behavioral Survey (YRBS), with baseline data from CY 01. Since this survey is administered in odd years, objectives have been set for the upcoming odd years.

Notes - 2003
The percent of high school students who report being in a physical fight in the past year.

This is a new measure. The data source will be the biennial Youth Risk Behavioral Survey (YRBS), with baseline data from 2001. Since this survey is administered in odd years, objectives have been set for the upcoming odd years. In 2003, 27% of high school students were in a physical fight in the 12 months preceding the survey. This represents a drop from 31 % in 2001.

(Note: The 2003 indicator was changed to include one decimal place in the FY06 block grant application. The revised indicator is 26.5%; the previously-reported indicator was 27%.)

Notes - 2004
The percent of high school students who report being in a physical fight in the past year.

The data source for this indicator is the Youth Risk Behavior Surveillance System (YRBS) which reports on the percentage of high school students who report being in a physical fight one or more times during the 12 months prior to the survey. The YRBS is conducted every other year during odd numbered year (1999, 2001, 2003, etc.). Hence, the 2004 indicator is taken from the 2003 administration of the survey.

a. Last Year's Accomplishments

During FY04 youth involved in the Maine Youth Action Network (MYAN) selected bullying and teasing as an important issue affecting teens across the state. Through a contract with the Bureau of Health (BOH), youth in three schools participated in this effort.

In spring 2004, three additional bullying prevention project schools re-administered the student

bullying survey. A total of 535 students in grades 3-8 were surveyed. Key findings included: the frequency of bullying behaviors decreased for specific behaviors, such as being called hurtful names, being hit, kicked or pushed, being teased in a mean way, and being left out of things on purpose. In one school, the percentage of students who reported they never said mean things to others increased by 29%, and those who never hit, kicked or pushed others increased by 14%. Maine Law and Civics Education (MLCE) continued to add new schools to the bullying prevention program, training over 150 staff in 4 schools during the period.

MLCE and the Peace Studies Program at the University of Maine collaborated on planning, conducting and evaluating a statewide youth mediators' conference held on May 11, 2004. 144 students (grades 4-12) and 37 coordinators attended from 20 elementary, middle, and high schools throughout Maine. All participated in a Circles of Connection activity, skill-building workshops, and networking activities.

MLCE trained 35 peer mediators and 3 coordinators in two high schools in southern Maine during this period. MLCE also conducted a fall 2003 peer mediation conference for 40 students and adult coordinators from 4 schools. Community mediators demonstrated the mediation process and coached the students to advance their skills.

Peace Studies staff continued to provide information, training, support, library resources and consultation services in the area of youth violence prevention (conflict management, diversity education, school climate, character and peace education) to K-12 educators and students in central and northern Maine, as well as at the University of Maine. These efforts included: publishing the Changing Ways Newsletter, which promotes conflict transformation and positive school climate in Maine schools (sent to every K-12 school principal and guidance counselor and 1500 other educators); training for 200 middle and high school peer mediators and coordinators in the skills and practice of conflict management and the Circles of Connection process, consulting with educators, disseminating information and curriculum materials, collaborating on various youth violence prevention committees at the University of Maine, promoting conflict resolution and diversity education through workshops, and continuing to coordinate the CMUM group (Conflict Management at U Maine), which includes ensuring that the mediation training courses are offered. During this time period, 39 students completed a 40-hour training course in the theory and practice of transformative mediation.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sponsor CMUM Peer Mediation Program for University of Maine students	X			
2. Sponsor the statewide PMAM for student mediators	X			
3. Provide northern and southern resource lending libraries for Youth Violence Prevention Programs and curricula		X		X
4. Provide training and TA to elementary, middle & high school staff & students in conflict management, peer mediation & bullying prevention programs				X
5. Evaluate the impact of the bullying prevention program in participating schools				X
6. Continue youth led bullying prevention activities in three Maine schools				X
7. Compile and disseminate data on youth violence statewide				X

8. Facilitate collaboration among key stakeholders, and coordinate activities to prevent youth violence				X
9.				
10.				

b. Current Activities

Peace Studies conducted three conferences in the area of conflict management in Fall 2004; one for middle school peer mediators in October (52 participants from 5 schools); one for high school students in December (38 participants from 3 schools); and one for peer mediation coordinators in October (4 participants from 3 schools). Attendees at all three events gave high evaluation in terms of skills learned and usefulness of material presented. Peace Studies published the Fall 2004 issue of Changing Ways Newsletter (with a circulation of all K-12 schools, total issues mailed, 3000) and will produce an issue in Spring 2005. Additionally, Peace Studies offered, and will continue to offer, library resources and consultations on youth violence prevention concerns and issues to K-12 schools from the central and northern Maine region. Peace Studies staff trained 4 University of Maine students in the Circles of Connection facilitation process in February 2005 and is offering a similar training for high school teams (students, faculty, administrators, parents) in April 2005.

Peace Studies and MLCE completed in June 2005, a Peer Mediation Manual that will support efforts to start or strengthen peer mediation programs in K-12 schools in Maine. Finally, during this time period, the mediation training will have been offered 5 times to students at the University of Maine.

MLCE conducted 3 conferences in fall 2004 at the University of Southern Maine: one for peer mediation coordinators (9 participants from 6 schools); one for high school peer mediators (40 students and 4 coordinators from 3 schools); and a middle school peer mediation workshop (20 students and 1 coordinator). MLCE also conducted peer mediation training at a Portland middle school, training 20 students and 2 coordinators in peer mediation skills.

MLCE added 4 new schools to the bullying prevention project, and continued bullying prevention work with 3 schools. The work included staff and coordinating committee training and technical assistance, bus driver training, parent awareness, and all-school bullying prevention kick-off events. By June 2005, MLCE will have a revised Bullying Prevention Coordinator Manual, and will make it available to schools in printed and web-based formats.

MLCE staff are participating actively in the state-level Task Force on Citizenship Education, chairing the Best Practices Subcommittee which will develop a comprehensive "civic discourse" model for schools, along with a resource guide and professional development plan for implementation.

c. Plan for the Coming Year

Provide conflict management, peer mediation and bullying prevention training programs and implementation consultation to schools statewide

Conduct a Northern and Southern Maine Peer Mediation Association of Maine Conference for students and staff from middle and high schools statewide

Conduct regional Peer Mediation Association of Maine workshops

Develop and promote Circles of Connection process in schools for improving school climate and strengthening school communities

Offer mediation training courses at the University of Maine

Continue development of a comprehensive "civic discourse" model for Maine secondary schools, which includes best practices in conflict management and youth empowerment

Purchase resources and curricula for loan to trainers and schools statewide

Produce and disseminate, Changing Ways, Newsletter for school staff

Continue facilitation of youth involvement in an interagency state-level group through the Maine Youth Action Network.

State Performance Measure 13: *To increase the percentage of children with special health care needs less than or equal to 18 years of age in Maine receiving comprehensive care coordination.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					
Annual Indicator			0	0	0
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

To increase the percentage of children with special health care needs less than or equal to 18 years of age in Maine receiving comprehensive care coordination.

Data are not available for this measure and it will be phased out.

The proposed numerator was the number of children receiving services through the State's Medicaid Primary Case Management Program. However, the case management provided by that program is not equivalent to comprehensive care coordination within a medical home.

The proposed denominator was to be obtained from the National Survey of Children with Special Health Needs and was the number of children eligible for Medicaid, not the number actually enrolled in Medicaid, which is the denominator needed to accurately calculate this measure (i.e., the number of children with special health needs enrolled in Medicaid who are getting comprehensive care coordination divided by the number of children with special health

needs enrolled in Medicaid).

The concept addressed by this measure is covered adequately by National Performance Measure #3.

Note: TVIS requires entry of an estimate for this indicator; since no data are available, we entered 0.

Notes - 2003

To increase the percentage of children with special health care needs less than or equal to 18 years of age in Maine receiving comprehensive care coordination.

Data are not available for this measure and it will be phased out.

The proposed numerator was the number of children receiving services through the State's Medicaid Primary Case Management Program. However, the case management provided by that program is not equivalent to comprehensive care coordination within a medical home.

The proposed denominator was to be obtained from the National Survey of Children with Special Health Needs and was the number of children eligible for Medicaid, not the number actually enrolled in Medicaid, which is the denominator needed to accurately calculate this measure (i.e., the number of children with special health needs enrolled in Medicaid who are getting comprehensive care coordination divided by the number of children with special health needs enrolled in Medicaid).

The concept addressed by this measure is covered adequately by National Performance Measure #3.

Note: TVIS requires entry of an estimate for this indicator; since no data are available, we entered 0.

Notes - 2004

To increase the percentage of children with special health care needs less than or equal to 18 years of age in Maine receiving comprehensive care coordination.

Data are not available for this measure and it will be phased out.

The proposed numerator was the number of children receiving services through the State's Medicaid Primary Case Management Program. However, the case management provided by that program is not equivalent to comprehensive care coordination within a medical home.

The proposed denominator was to be obtained from the National Survey of Children with Special Health Needs and was the number of children eligible for Medicaid, not the number actually enrolled in Medicaid, which is the denominator needed to accurately calculate this measure (i.e., the number of children with special health needs enrolled in Medicaid who are getting comprehensive care coordination divided by the number of children with special health needs enrolled in Medicaid).

The concept addressed by this measure is covered adequately by National Performance Measure #3.

Note: TVIS requires entry of an estimate for this indicator; since no data are available, we entered 0.

a. Last Year's Accomplishments

This measure was discontinued in FY02.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This measure was discontinued in FY02				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

c. Plan for the Coming Year

E. OTHER PROGRAM ACTIVITIES

Dr. Aronson, MCH Medical Director, convened a planning meeting on June 11, 2003, to develop methods for incorporating Shaken Baby Syndrome into the public health context for child abuse and neglect prevention.

Inspired by the shared information and effective awareness and prevention models, Dr. Aronson organized a partnership of state agencies, private institutions, local evaluators experienced in child welfare, and child abuse and neglect councils. The partnership cultivated a project proposal to the Centers for Disease Control and Prevention, Safe Start Maine, which intends to develop evidence-based recommendations to reduce the incidence of serious physical abuse in the birth to three population. With its rigorous research, design, intervention, and evaluation components, Safe Start Maine strengthens BOH leadership in violence prevention throughout the state.
/2006/ Although this proposal was not funded by the CDC, the partnership that emerged from it continues to seek opportunities for such a project, and we hope that the hiring of the new MCH doctoral level epidemiologist in June 2005 will bring to fruition another proposal. //2006//

Complementing the collaborative work of Safe Start Maine to further highlight the need for an integrated and comprehensive public health approach to child abuse and neglect, the Bureau of Health continued to strengthen its primary and secondary child abuse and neglect prevention strategies through the following activities:
1. Active leadership on the Children's Cabinet Task Force on Early Childhood, particularly through the Early Childhood Comprehensive Systems grant (Humane Systems for Early Childhood), to develop policies for parent education to prevent the risk of child abuse and neglect.
2. Leadership in convening a Department of Health and Human Services (DHHS) conference for 100 people in Augusta on July 30, 2003, "Stop Child Abuse". The Portland Press Herald headlined the conference as: "Agencies confer on curbing child abuse. Advocates say Mainers need to view child abuse as a public health threat."
3. Leadership in organizing and following up on a telephone consultation in September, 2003 with staff

(Corinne Graffunder, John Lutzker, Rebecca Leeb) from the Division of Violence Prevention at the CDC. This conversation, which involved Maine DHS staff from Child Protection, Children's Cabinet, Injury Prevention, and Title V, focused on ways that Maine could enhance its state health agency capacity to address child abuse through a linked data collection and tracking system. The consultation resulted in two CDC grant proposals submitted in December 2003: Safe Start Maine and The Maine Project: Linking Home Visitor Training and Family Outcomes.
4. Participation in press conferences about child abuse and neglect, including Fight Crime! Invest in Kids and the Child Abuse and Neglect Prevention month.
5. Media campaign development, in partnership with the Maine Children's Trust, Child Abuse and Neglect Councils, and Parent Education and support providers to provide consistent messaging about the recognition of parenting challenges and offer alternative approaches and supports to prevent abuse.
6. Researching and developing a systematic approach to home visitor training through the Maine Project, another CDC grant, that Title V submitted this year. The project proposes to evaluate the best practices in applied behavioral and attitudinal skills of home visitors and incorporate them in a statewide curriculum designed to reduce child abuse and neglect.

In April 2004, the Bureau of Health applied to the CDC for funding the Maine Violent Death Reporting System Cooperative Agreement. This proposal, with Dr. Aronson and Cheryl DiCara (Injury Prevention Program Manager) as principal investigators, includes a significant expansion and enhancement of the Child Death and Serious Injury Review Panel (CDSIRP). All cases reviewed by the panel to date have in common the suspicion of child abuse or neglect as a cause of death or a significant causal factor. The selection of cases is not systematic and the collection of data is not standardized. Between 1998 and 2003, the panel reviewed 29 child deaths for an average of roughly five per year. The panel focuses primarily on increasing the responsiveness of the child protection system and to promote the education of both professionals and the public.

In preparing the CDC Cooperative Agreement proposal, Dr. Aronson and Ms. DiCara engaged in a rich dialogue with the Child Death Panel in early April 2004. Panel members enthusiastically agreed to expand the review process to include all cases of violent child death (birth to 18) and to make it part of the Maine Violent Death Reporting System (ME-VDRS). This CDC Cooperative Agreement will allow for the Child Death Review Panel's reviews and reports to become much more systematic and uniform, substantially enriching the potential for policy and system change. As a result, we will gain valuable new information about child deaths from suicides, homicides, and firearms not related to child abuse. This information will be of vital importance in the design and implementation of best practices to prevent such deaths.

/2006/ In spite of not receiving funds for this Cooperative Agreement, Maine will continue to pursue opportunities to put this protocol into place.

During the past year, the focus of the Maine Injury Prevention and Control Program shifted to an intense and sustained concentration on youth suicide prevention. This included a Governor's Proclamation with a charge to revise the state's suicide prevention plan, a CDC investigation of a possible cluster of youth suicide in several mid-coast communities, and the submission of a major SAMHSA grant proposal that would provide support for a significant expansion of our current prevention efforts. See elsewhere in this application for details. //2006//

F. TECHNICAL ASSISTANCE

Please refer to Form #15. We will request technical assistance from the Maternal and Child Health Bureau and other appropriate entities such as other State Public Health Agencies, Academic Institutions with expertise in public health and public administration, non-profit organizations with MCH/CSHN expertise, and other federal partners such as the Centers for Disease Control and Prevention for the following:

1. Assistance with financial analysis of MCH resources and development of a plan for appropriate reallocation.
2. Technical assistance for cultural and linguistic competence within Title V programs.
3. Development of a formal strategic plan for the CSHN program.
4. Technical assistance on sampling methodology.
5. Technical assistance on qualitative data analysis
6. Technical assistance on implementing strengths based assessment.

The above requests for technical assistance are in order of priority.

Technical assistance #1 was selected because both the federal and state funds available to Maine Title V are fully utilized with no capacity to respond to emerging issues. Reallocation of funds need to be made in a thoughtful manner that avoid negative impacts upon Maine's many positive outcomes such as low adolescent birth rate, low infant mortality rate, high immunization rate, and high newborn screening rate. No progress was made in this area and remains a priority in FY 06 as Maine implements its 5 year priorities.

The request for technical assistance #2 was selected in order to continue progressing in the development of culturally and linguistically competent Title V programs in Maine. This is particularly important as the population in Maine becomes more racially, ethnically, and economically diverse.

The request for technical assistance #3 was selected because the CSHN Program has historically focused upon the provision of direct health services. The Program needs a process to get all internal and external stakeholders invested in the move toward population and infrastructure based services. It also needs a written plan that can be shared with others as well as frequently referred to when making decisions regarding the use of human and financial resources for the CSHN population.

The request for technical assistance #4 was selected because the Department of Education, the Bureau of Health and the Office of Substance Abuse Services are working together to create a coordinated approach for the design and administration of its 3 youth surveys Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS), and Maine Youth Drug and Alcohol Use Survey (MYDAUS). A single survey is not feasible because of the large number of questions required for inclusion. A sampling-only solution wherein some schools receive the YRBS, some the YTS and some the MYDAUS will not meet the program need and community desire for more local-level data. We see assistance with the sampling component of the survey, since only a non-traditional approach is likely to success.

The request for technical assistance #5 was selected in preparation for the 2010 comprehensive strengths and needs assessment (CSNA). Inclusion of qualitative data in the CSNA is important for adding a voice, face and humanity to the assessment. The body of research on the inclusion of qualitative data in assessments of need has grown in recent years. Technical assistance for quantifying qualitative data will allow us to conduct a comprehensive review and analysis of information gathered from focus groups for the 5 year assessment, for use in investigative studies, and will build additional capacity of knowledge and skill within the Epidemiology Team.

The request for technical assistance #6 was selected in preparation for the 2010 CSNA. During the development of the 2005 CSNA, understanding of the general concept of strengths based assessment was developed; however many questions remained regarding how does one really conduct an assessment of strengths. The literature has grown in the area of assessing individual strengths, but it was very difficult to locate literature and guidance regarding assessment of the strength of systems. From an epidemiologic perspective questions remain on how to integrate data from multiple sources; how to choose a model; how to put the concept of a strengths based assessment into practice/action. Technical assistance in this area will assist the state of Maine in conducting the 2010 Comprehensive Strengths and Needs Assessment. Based on responses to the Region I workshop on including strengths in the comprehensive needs assessment, it appears the

interest in this topic is shared widely among Title V programs in the US.

V. BUDGET NARRATIVE

A. EXPENDITURES

For a summary of any variances please refer to Section VB - Budget.

B. BUDGET

The Division of Family Health expended $17,514,463 for maternal and child health services in FY04; including $14,285,294, of state funds and $3,229,169 of Title V funds. Expenditures by populations served include 63% ($11,084,682) expended on primary care and preventive services for children; 18% ($3,121,580) expended for children with special health care needs; and 14% ($2,414,949) expended for pregnant women. Delineating expenditures by the levels of the MCH Core Services Pyramid, 56% ($9,791,611) was expended on direct services; 7% ($1,158,806) was expended on enabling services; 9% ($1,496,056) was expended on population based services; and 29% ($5,067,990) was expended on infrastructure building services. The slight decrease in direct, enabling and population based service expenditures supported a 7% increase in expenditures for infrastructure services. Overall expenditures in FFY 04 appear to be approximately 4 million more than budgeted. Unfortunately this is not a result of the Title V Program obtaining additional funds; rather the funds were expended in FFY 03. Both state and federal allotment problems in FFY 03 delayed payment until FFY 04. In FY06 the Division proposes to spend $3,507,117of Title V funds, with no carry forward from FY05. Of the Title V funds, 63% ($2,209,973) is allocated to primary care and preventive services for children; 31% ($1,076,661) is allocated to children with special health care needs; and 6% ($220,483) is available for administrative expenses. Considering the total federal and state budgets, the Division proposes the following expenditures, categorized by level of the MCH Core Services pyramid: 68% ($9,584,140) will be allocated for direct services; 8% ($1,094,546) for enabling services; 9% ($1,203,104) for population based services; and 15% ($2,059,629) for infrastructure building services.

In FY06 proposed budgeted expenditures are on par with the FY 05 budget. Despite continued challenges of balancing budget deficits this reflects some stabilization in funding. Reductions appear level with those of FY05. FY 05 and FY06 reductions are reflected in a 5% reduction in funds for purchased services, others are reflected in reduced positions and yet others are in administrative and material expenses. Included in the annual MCHBG budget is $22,500 to cover expenses related to out of state travel to attend regional or national meetings that are important for continuing to move forward in advancing the health of the MCH population. These funds will be used by staff in the programs working with the MCH population on the priorities outlined in the comprehensive strengths and needs assessment

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.